"CRITICAL ANALYSIS OF ROLE OF INSURANCE OMBUDSMAN IN INDIA "

A DISSERTATION TO BE SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF DEGREE OF MASTER OF LAWS

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CERTIFICATE

This is to certify that the research work entitled **"CRITICAL ANALYSIS OF ROLE OF INSURANCE OMBUDSMAN IN INDIA"** is the work done by a student of Babu Banarsi Das University, Lucknow , under my guidance and supervision for the partial fulfillment of the requirement for the Degree of (LLM) in BabuBanarsi Das University Lucknow, Uttar Pradesh. According to the best of my knowledge, he/she has fulfilled all the necessary requirements prescribed under the University Guideline with regard to the submission of this dissertation.
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LIST OF ABBREVIATIONS

- **CIO- Council for Insurance Ombudsman**
- **IRDAI- Insurance Ragulator Development Authority**
- **FDI- Foreign Direct Investment**
- **LPG- Liberalized, Private and Globalized**
- **FSLRC- Financial Sector Legislative Reforms Commission**
- **ICT- Information and Communication Technology**
- **ALL- Acute Lumphoblastic Leukaemia**
- **IFSO- Insurance and Financial Complaints Authority**
- **AFCA- Australian Financial Complaints Authority**
- **FOS-Financial Ombudsman Service**
- **ESI- Employee State Insurance**
- **PF- Provident Fund**
- **LIC- Life Insurance Corporation**
- **GATS-General Agreement Trade in Service**
- **WTO- World Trade Organization**
- **GIC- General Insurance Corporation**
- **IIPA- Indian Institution of Public Administration**
- **NCDRC- National Consumer Dispute Redressal Commission**
- **SBI- State Bank of India**
- **RBI- Reserve Bank of India**
- **PNB- Punjab National Bank**
- **USA- United States of America**

- **UK- United Kingdom**
- **AIR- All India Report**
- **RSBY-Rashtriya Swasthya Bima Yojana**
- **CBHI- Community Based Health Insurance**
- **TPA- Third Party Administration**
- **NGO- Non- governmental Organization**
- **NCDRC- National Consumer Disputes Redressal Commission**

CHAPTER-I

INTRODUCTION

The Offices of Insurance Ombudsman are under the administrative control of Council for Insurance Ombudsmen (CIO), which has been constituted under the Insurance Ombudsman Rules, 2017.

Office of Insurance Ombudsman is an alternate Grievance Redressal platform which has been setup with an aim to resolve grievances of aggrieved policyholders Among the various types of insurance coverage available to individuals, group insurance policies offered to sole proprietors and micro enterprises aim to provide affordable and unbiased protection. These policies are designed to safeguard these entities against risks, ensuring fair treatment by insurance companies, as well as their agents and intermediaries. Insurance Companies and their agents and intermediaries in a cost-effective and impartial manner.

There are 17 Ombudsman Centres, covering the country, situated in Ahmedabad, Chandigarh, Chennai, Delhi, Guwahati, Hyderabad, Jaipur, Kochi, Bengaluru, Bhopal, Bhubaneswar, Kolkata, Lucknow, Mumbai, Noida, Pune and Patna.

The Insurance Ombudsmen are appointed by the Council for Insurance Ombudsmen in terms of Insurance Ombudsman Rules, 2017 (as amended from time to time) and empowered to receive and consider complaints Accusing an insurer, including its agents and intermediaries, or an insurance broker of failing to meet the expected level of performance. on any of the following grounds:

1. Delay in settlement of claims

2. Any instance where the life insurer, general insurer, or health insurer rejects or denies either a portion or the entire claim submitted by the policyholder..

3. Conflicts arising from the payment or amount of premiums in relation

4. The act of providing inaccurate or misleading information regarding the terms and conditions of an insurance policy, either intentionally or unintentionally, within the policy document or contract.

5. The interpretation of insurance policies from a legal standpoint, particularly when it pertains to resolving disputes regarding claims.

6. "Grievances related to the handling of policy services, including complaints against insurers, agents, and intermediaries."

7. "The issuance of a life insurance policy, general insurance policy, or health insurance policy that does not align with the information provided in the proposal form submitted by the policyholder.".

8. "The failure to issue an insurance policy, despite receiving the premium payment, in both life insurance and general insurance, including health insurance.".

9. "Any additional issue that arises due to the failure to comply with the regulations established by the Insurance Regulatory and Development Authority of India (IRDAI) for safeguarding the interests of policyholders. This includes non-compliance with regulations, instructions, or guidelines issued by the IRDAI, as well as the violation of terms and conditions specified in the policy contract, provided that such matters are related to the aforementioned clauses."

"During his Congressional statement on March 15, 1962, U.S. President John F. Kennedy highlighted the significance of consumers, stating, 'Consumers by definition include us all.' He emphasized that consumers form the largest economic group, influencing and being affected by nearly every public and private economic decision. However, their voices were often unheard. This message spurred the adoption of pro-consumer legislations, marking a historic moment where a politician articulated such principles.

Subsequently, the United Nations Guidelines on Consumer Protection were developed, promoting an approach that encourages countries to tailor their consumer

protection policies to their specific populations, economic conditions, and environmental circumstances, rather than pursuing a one-size-fits-all approach based on global harmonization of laws and policies. These guidelines serve as a framework of principles to assist countries in crafting their legislations and policies, addressing seven essential consumer needs.

Recently, the United Nations Human Rights Council endorsed the Guiding Principles on Business and Human Rights, further emphasizing the importance of aligning business practices with human rights considerations."The “Guiding Principles on business and human rights”

The importance lies in aligning rights and obligations with appropriate and effective remedies when they are violated. In today's globalized economy, the service sector has transcended geographical barriers, and the values and ethics across regions may differ. In such circumstances, human rights serve as a common element that holds validity worldwide, and it is crucial to nurture these rights. Businesses operating within a global network must also adapt and plan their developments while adhering to guidelines for the betterment of human society.

India, being a welfare state, has certain responsibilities entrusted to the Union Government to ensure the essential protection and well-being of its citizens, and insurance is one such aspect. The preamble of the Indian Constitution assures socio-economic justice to all Indian citizens, ensuring equality of status, opportunity, and dignity of the individual. Article 21, with its expanded interpretation of the right to life, extends to encompass the right to livelihood. Article 38, within the Directive Principles chapter, mandates the state to promote the welfare of the people by establishing an effective social order based on socio-economic justice that permeates all national institutions. Article 39 guarantees the right to livelihood, health, and the well-being of workers, both men and women, as well as children of tender age. Social security is assured under Article 41, while Article 47 imposes a positive duty on the state to elevate living standards and improve public health.

In the case of Consumer Education and Research Centre v. Union of India, it was established that the right to health, medical aid, and the protection of a worker's health and well-being during and after employment is a fundamental right under Article 21, read in conjunction with Articles 39(e), 41, 43, and 48-A of the Constitution of India. These rights are considered essential human rights that give meaning and purpose to the lives of workers, ensuring their dignity and well-being.

The Supreme Court further emphasized that insurance, being a social security measure, should align with the constitutional principles of socioeconomic justice. Acting fairly is a crucial component of fair procedures outlined in Articles 14 and 21. Any action undertaken by a public authority or those with public duty or obligation must be rational and guided by the public interest.

The right to security against sickness and disability is recognized as a fundamental right under Article 25 of the Universal Declaration of Human Rights, Article 7(b) of the International Covenant on Economic, Social and Cultural Rights, and Articles 39(e), 38, and 21 of the Constitution of India. The Employees State Insurance Act aims to provide such security, maintaining the health of injured workers. The Supreme Court, in the case of Regional Director,

ESI Corporation v. Francis DeCosta

ESI Corporation v. Francis DeCosta, ruled that the interpretation should be such that it upholds the workman's fundamental right to medical benefits.

This research focuses on protecting insurance consumers, including both the life assured during their lifetime and claimants after the death of the life assured. The main discussion revolves around insurance law and consumer protection law. It is important to explore how the principles of consumer protection can be integrated with

insurance law and vice versa, for the benefit of consumers and the industry. The research endeavors to achieve this objective by analyzing various international conventions, United Nations guidelines, existing legal framework provisions, and regulatory directions. Due to the vastness of the subject of insurance, this research work is limited to life and health insurance voluntarily subscribed to by individuals, taking into account various limitations, time constraints, resource availability, and personal experience.

Before delving into the statement of the problem, reasons for the study, and study objectives, it is essential to explore some important aspects in the evolution and development of insurance law at both the international and Indian levels. This discussion will be presented under the introductory section.

The necessity for insurance arises from the presence of uncertainty that surpasses human comprehension. Such situations arise in both personal and business contexts. Insurance likely emerged when losses became unbearable. These losses are not a result of one's own actions but rather forces beyond control. In response, humans have devised means to cope with hazards driven by the instinct to survive. Insurance plays a crucial role in this endeavor. Its foundation lies in the fundamental principle of risk spreading and the prudence of preparing for an uncertain future while in a prosperous present.

As civilizations progressed and international trade flourished, the concept of insuring property emerged earlier than life insurance. Insurance offers security against the inherent uncertainties of human life. Its objective is to safeguard the policyholder from various anticipated risks. The fundamental purpose of insurance is to transfer the burden of loss from an individual to a willing and capable professional risk bearer. This transfer occurs through the mechanism of spreading the risk over a large group of individuals, ensuring that a potentially significant financial loss, which may be too

burdensome for one person to bear, can be managed collectively. Thus, insurance serves a social purpose by pooling individual risks into a group and enabling the reimbursement of those who experience smaller losses through small periodic contributions from the insured individuals.

One of the primary aims of insurance is to achieve a rational and equitable distribution of risk while facilitating actions that individuals might otherwise hesitate to undertake. It is important to note that this research focuses exclusively on the protection of consumer interests in life insurance and health insurance. The key legislations governing insurance in India include the Insurance Act of 1938, the Life Insurance Corporation of India Act of 1956, and the Consumer Protection Act of 1986, which specifically addresses consumer protection concerns.

The insurance sector in India opened up to private players in 1999, leading to the enactment of the IRDA Act in the same year.[1] Several important legislations address various aspects of insurance and consumer protection, such as the Marine Insurance Act of 1963, Indian Contract Act of 1872, Married Women's Property Act, and Companies Act of 1956.[2] Additionally, subordinate rules like Insurance Rules, Consumer Protection Rules, and Redressal of Public Grievance Rules are in place and will be discussed in relevant sections of this research work. However, the main focus will be on the aforementioned three crucial legislations and the proposed amendment to the Insurance Act. The researcher conducts a thorough analysis of various Law Commission Reports on insurance and related issues to provide comprehensive insights into the subject.

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[1] IRDA Act, 1999.

[2] . Marine Insurance Act, 1963; Indian Contract Act, 1872; Married Women's Property Act; Companies Act, 1956.

It is important to note that protecting consumer interests in insurance transactions is not lacking in terms of legal provisions or knowledge. However, in practice, consumers often face difficulties and problems that need to be addressed. This research aims to identify and propose solutions for these challenges.

STATEMENT OF THE PROBLEM:

1. India being a Welfare State, insurance is considered a welfare measure. The state has a responsibility to protect its citizens in cases of old age, sickness, disablement, and other situations of undeserved want, as outlined in Article 41 and other articles of the Constitution.

2. In a competitive market, consumers often lack the right to choose, access to information, and other rights as envisioned in the UN Declaration on Consumer Protection.

3. Intermediaries play a significant role in insurance contracts, but their interests often conflict with those of consumers due to a remunerative pattern.

4. Insurance contracts are governed by the principle of utmost good faith, which expects consumers to have a duty of good faith and an obligation towards the insurer. However, this expectation often falls short in reality, and exploring ways to ensure compliance is necessary.

5. Consumers face difficulties when intermediaries engage in misconduct and provide misinformation. The existing statutes and legislations are insufficient in regulating insurance intermediaries.

6. Consumer forums and state commissions established under the Consumer Protection Act of 1986 often lack a systematic legal procedure. This situation undermines the effectiveness of the Consumer Protection Act.

7. The implications and outcomes of the proposed Insurance Laws (Amendment) Bill of 2008 require a thorough examination considering the Indian context, cultural nuances, and religious beliefs. Specifically, the issue of intestate succession for Muslim policyholders and female policyholders whose intestate succession affects property rights needs careful consideration.

REASONS FOR THE PRESENT STUDY AND ITS IMPLICATIONS:

The current study is motivated by several factors and aims to explore the implications of the findings. The global life insurance premium, as highlighted in the World Insurance Report published by leading reinsurance company "Swiss Re," experienced a growth of 2.3 percent in 2012, reaching USD 2,621 billion in real terms (adjusted for inflation). This positive growth followed a contraction of 3.3 percent in 2011, with emerging markets driving the resurgence.

To evaluate the performance of the insurance sector, two key parameters are commonly used: insurance penetration and insurance density. These parameters help gauge the level of development of the insurance sector within a country. Insurance

penetration refers to the ratio of premium underwritten in a given year to the Gross Domestic Product (GDP). On the other hand, insurance density represents the ratio of premium underwritten in a given year to the total population, measured in USD for ease of comparison[3].

Understanding the reasons behind the growth or contraction of the insurance sector, as well as the factors influencing insurance penetration and density, is crucial. By examining these aspects, the study aims to shed light on the potential opportunities and challenges faced by the insurance industry. Additionally, it seeks to explore the impact of insurance on the overall economic development of countries, particularly in terms of providing financial security to individuals and fostering economic resilience.

By delving into these factors, the study hopes to contribute valuable insights to policymakers, insurance companies, and other stakeholders. It seeks to provide a deeper understanding of the dynamics of the insurance market and its significance in driving economic growth and social welfare. The insurance penetration and density in India is given in Table1.1.

INSURANCEPENETRATIONANDDENSITYININDIA						
Year	**Life**		**Non-Life**		**Industry**	
	Density(USD	**Penetration(Percentage)**	**Density(USD)**	**Penetration(Percentage)**	**Density(USD)**	**Penetration(Percentage)**
2001	9.10	2.15	2.40	0.56	11.50	2.71

[3] . Insurance penetration and insurance density are widely used metrics to assess the level of development of the insurance sector. Insurance penetration is calculated by dividing the premium underwritten in a given year by the GDP, while insurance density is calculated by dividing the premium underwritten by the total population, both measured in USD for comparability

2002	11.7	2.59	3.00	0.67	14.70	3.26
2003	12.9	2.26	3.50	0.62	16.40	2.88
2004	15.7	2.53	4.00	0.64	19.70	3.17
2005	18.3	2.53	4.40	0.61	22.70	3.14
2006	33.2	4.10	5.20	0.60	38.40	4.80
2007	40.4	4.00	6.20	0.60	46.60	4.70
2008	41.2	4.00	6.20	0.60	47.40	4.60
2009	47.7	4.60	6.70	0.60	54.30	5.20
2010	55.7	4.40	8.70	0.71	64.40	5.10
2011	49.00	3.40	10.00	0.70	59.00	4.10
2012	42.7	3.17	10.50	0.78	53.20	3.96

Source:IRDAAnnualReport2012-13.

Based on the available information, it can be inferred that the Life Sector of the Indian insurance market experienced a period of growth until 2009, but subsequently faced a decline. In contrast, the Non-life Sector exhibited a steady increase in insurance penetration[4]. To understand the underlying reasons for these trends, further investigation is required.

Furthermore, the Health Insurance sector has emerged as a rapidly growing segment within the Indian insurance market. This growth can be attributed to various factors such as enhanced customer focus, industry-wide standardization of procedures and definitions, advancements in medical technology, and the rising demand for better healthcare services[5].

[4] Detailed data and analysis on the trends in the Life and Non-life Sectors of the Indian insurance market would be required to fully understand the factors contributing to the observed patterns.

[5] The growth of the Health Insurance sector can be attributed to factors such as customer-centric approaches, industry-wide standardization, medical advancements, and evolving healthcare expectations of individuals.

As of September 2013, there were a total of 52 insurance companies operating in India, with 24 engaged in the life insurance business and 27 in the non-life insurance sector. Among the non-life insurers, four were standalone health insurance providers. Out of the 52 companies, eight were in the public sector, while the remaining forty-four were in the private sector[6].

The demand for Health Insurance has been on the rise due to advancements in medical technology and the growing aspiration for improved healthcare. With the Indian insurance market being open for over fourteen years, the recent approval of increasing the Foreign Direct Investment (FDI) limit in the insurance sector from 26% to 49% by the government is expected to further stimulate industry growth[7].

However, alongside such policy changes, there arises a parallel need to safeguard consumer interests. With a liberalized, private, and globalized economy, often referred to as LPG, consumer interests can face strain at various stages of transactions. This highlights the importance of implementing regulatory measures and safeguards to ensure adequate consumer protection within the insurance sector[8].

In a modern, privatized, and globally interconnected economy, commonly referred to as an LPG economy, the interests of consumers in the insurance industry can often be strained during various stages of transactions. In such a competitive environment where profit and success are primary objectives, it becomes paramount to safeguard the interests of insurance consumers and ensure they receive the entitled benefits without unnecessary complications.

[6] The numbers mentioned are based on the information available as of September 2013 and may have changed since then. The distribution of insurance companies between the public and private sectors provides an overview of the market landscape

[7] The increase in the FDI limit in the insurance sector is a recent policy change that aims to attract more foreign investment and foster industry growth

[8] In a liberalized, private, and globalized economy, consumer interests may face challenges and require appropriate regulatory measures to ensure protection throughout insurance transactions

Consumer protection measures play a crucial role in fostering a fair and transparent insurance market. It is imperative to have regulations and policies in place to safeguard consumer rights and ensure equitable treatment throughout the insurance process. This includes clear and concise communication of terms and conditions, transparent disclosure of policy details, and prompt settlement of claims[9].

While protecting consumer interests is important, it is equally necessary for insurance companies to operate profitably and effectively serve the public. Striking a balance between providing comprehensive coverage and maintaining a sustainable business is crucial. This involves managing risks, ensuring financial stability, and offering competitive products and services[10].

In order to achieve these objectives, insurance regulators and policymakers play a vital role. They establish frameworks and guidelines that promote fair competition, protect consumers, and maintain the stability of the insurance industry. Effective supervision and enforcement of regulations are necessary to uphold integrity and foster trust in the insurance market[11].

Overall, in an LPG economy, it is essential to protect the interests of insurance consumers through appropriate regulations and consumer-centric policies. Simultaneously, insurance companies should be able to operate profitably and fulfill their role in serving the public. Striking the right balance between consumer

[9] Consumer protection measures should encompass clear communication, policy transparency, and efficient claims settlement to ensure fair treatment throughout the insurance process

[10] Insurance companies need to find a balance between profitability and effectively meeting the needs of consumers, encompassing risk management, financial stability, and competitive offerings.

[11] Regulators and policymakers are responsible for establishing frameworks and guidelines that promote fairness, consumer protection, and industry stability through effective supervision and enforcement.

protection and business viability is crucial for a sustainable and efficient insurance industry.

As a researcher with significant experience in the insurance field, particularly in legal matters, I hold the viewpoint that insurance contracts should be designed to be simple, clear, and consumer-oriented. This perspective underscores the importance of ensuring that insurance policies are easily understandable for consumers, free from complex language or hidden clauses that could lead to confusion or disputes[12].

Furthermore, the researcher suggests that intermediaries in the insurance industry should play an enhanced role, and stringent legislation should be enacted to ensure their accountability and promote consumer-friendly practices. It is crucial to have regulations and measures in place that hold intermediaries responsible for acting in the best interest of consumers, providing accurate information, and maintaining transparency in their dealings.

The statement also acknowledges the significance of the Consumer Protection Act, 1986, which has been in effect for more than two decades. This act serves as a vital legal framework in India, safeguarding consumer rights across various industries, including insurance. It establishes consumer forums and provides mechanisms for consumers to seek redressal for grievances and unfair treatment.

Overall, the researcher's viewpoint highlights the importance of simplifying insurance contracts, enhancing the role of intermediaries, and implementing strict legislation to protect the interests of insurance consumers. These measures aim to ensure transparency, fairness, and consumer-friendly practices within the insurance industry.

[12] Simplicity, clarity, and consumer-centric design are crucial elements in insurance contracts to prevent misunderstandings and disputes, enhancing consumer confidence in the insurance industry.

The statement raises a concern regarding the Consumer Protection Act, 1986, particularly the ambiguity surrounding the proceedings under the act. It is unclear whether the proceedings are summary in nature or follow the regular trial procedure based on the Civil Procedure Code. This lack of clarity can lead to fundamental flaws in the consumer protection process, forcing consumers to engage in protracted legal battles with large insurance companies, often depleting a significant portion of their claim amount.

To address this issue, there is a pressing need for a uniform procedure to be followed by all consumer forums. Implementing a standardized and clear procedure would ensure consistency and transparency in resolving consumer disputes related to insurance, alleviating the burdens faced by consumers and enhancing the efficiency of the redressal process.

This would enable consumers to have a clear understanding of the process and ensure that they have a fair opportunity to present their case effectively.

Furthermore, the statement emphasizes the need for a thorough examination of the issue of prolonged legal battles faced by beneficiaries. This indicates that there may be underlying factors contributing to the delays in resolving consumer disputes, such as procedural complexities, insufficient resources, or systemic issues. By conducting a detailed analysis of these problems, appropriate measures can be implemented to streamline the process and ensure timely resolution of consumer complaints.

In summary, the concerns raised highlight the importance of establishing a clear and uniform procedure to be followed in consumer forums. Addressing the issue of prolonged legal battles is essential to safeguard the rights of consumers and provide

them with an efficient and accessible mechanism for resolving disputes with insurance companies.

The study conducted by the Centre for Consumer Studies at the Indian Institute of Personnel Administration in five states (Gujarat, Karnataka, Odisha, Tripura, and Uttar Pradesh) aimed to evaluate the impact and effectiveness of the Consumer Protection Act, 1986. Figure 1.1 below presents an important finding from the study regarding the delay in Consumer Forums.

According to the Consumer Protection Act, a complaint should ideally be resolved within three months from the date of notice received by the opposite party, or within five months if commodity testing is required. However, the study revealed that 72.3% of respondents agreed that complaints were not disposed of within the mandated 3/5-month timeframe specified by the Act. Only 27.7% of respondents stated that complaints were indeed resolved within the specified timeframe.

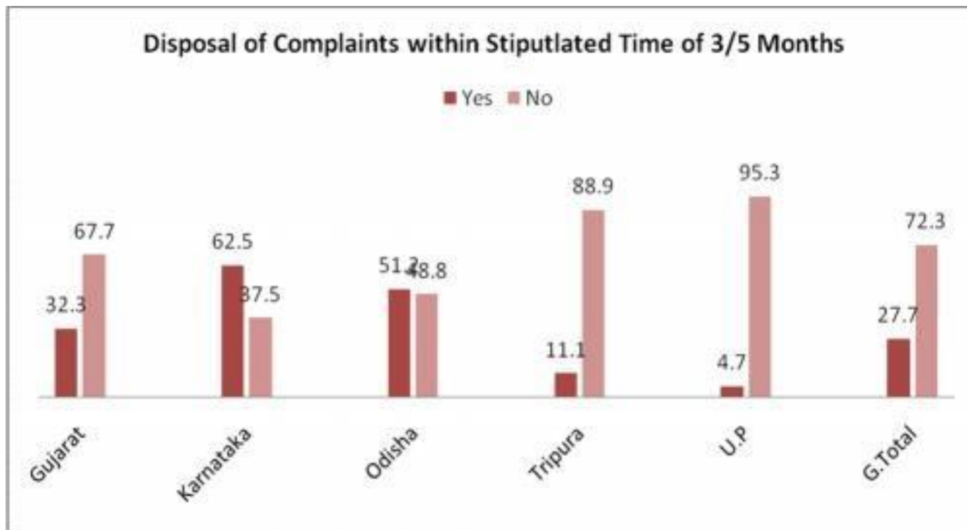
This finding highlights a significant gap between the expected timeline for complaint resolution as per the Consumer Protection Act and the actual time taken by the Consumer Forums. The delay in disposing of complaints contributes to the prolonged legal battles mentioned earlier, where consumers have to endure extended waiting periods for resolution.

The statement highlights the necessity for conducting a dedicated and professional study to comprehensively understand and identify the causes behind the delays and challenges experienced by beneficiaries in the consumer justice process. It suggests that the current laws and legal systems exhibit fundamental flaws in delivering consumer justice within the prescribed timeframes.

In order to address these issues, it is essential to rectify the underlying weaknesses in the statutes and legal system. This may involve revising and enhancing existing laws and regulations, as well as exploring alternative approaches to ensure the timely resolution of consumer complaints.

Figure:1.1

Source:FieldSurvey,CentreforConsumerStudies,IIPA



Additionally, the statement points out the absence of a specific law to regulate insurance intermediaries, who are currently governed by the Law of Agency. Even in the case of the public sector Life Insurance Corporation of India, which is regulated by Rules 18, there is a lack of clear accountability and enforceable penalties. This underscores the need for comprehensive regulations and oversight mechanisms to govern insurance intermediaries, thereby promoting transparency and safeguarding consumer interests.

With regards to health insurance, the statement emphasizes the significance of consumers being well-informed about the terms and conditions of their contracts prior to encountering any contingencies. It highlights that exclusion clauses often come to the consumer's attention only when making a claim, leading to difficulties and dissatisfaction. Therefore, a conceptual shift is necessary in drafting the terms and conditions of health insurance policies to ensure clarity and fairness.

Furthermore, it notes the potential risks associated with relying solely on health insurance to drive the medical treatment system, as it may exclude those without insurance coverage. It underscores the importance of developing medical facilities in line with those in developed countries, while taking into account the unique challenges faced in the Indian context, such as a large population, unemployment, and limited awareness.

In conclusion, the statement emphasizes the need for comprehensive studies, reforms, and conceptual changes to address the deficiencies in the legal system, regulations governing intermediaries, and the terms and conditions of insurance contracts. It also highlights the importance of balanced and inclusive development of healthcare infrastructure.

Over the years, multiple law commissions have examined the provisions of the Insurance Act of 19 and submitted reports. However, the law remains unchanged since its original enactment, thereby perpetuating the difficulties faced by insurance consumers. The statement raises concerns that opening the insurance market to private players in a critical sector could potentially lead to an increase in disputes, further exacerbating the challenges faced by consumers. It emphasizes the urgency of addressing this issue and continuously reviewing measures to ensure consumer protection within the insurance sector.

REVIEW OF EXISTING LITERATURE

From the legal framework, the researcher conducted an extensive review of existing literature in two main areas: life insurance and health insurance. While marine insurance has received more attention historically, the researcher found valuable materials, including texts and articles by renowned authors, to gain insights into life insurance.

The literature review encompassed a comprehensive examination of different aspects related to life insurance. This involved studying the various types of life insurance policies, their characteristics, and the factors influencing the growth and performance of the life insurance sector. Additionally, the review explored concepts such as insurance penetration and insurance density, which are utilized to assess the development of the insurance sector in different countries.

Regarding health insurance, the researcher analyzed the rapidly expanding sector and identified the drivers behind its growth. The literature emphasized factors such as improved customer orientation, standardized procedures and definitions, advancements in medical technology, and the growing demand for enhanced healthcare. These findings provided valuable insights into the drivers of growth in the health insurance industry.

Furthermore, the literature review focused on the role of intermediaries in the insurance industry. It underscored the significance of intermediaries acting in the best interests of consumers, providing accurate information, and maintaining transparency in their dealings. The review also highlighted the necessity for stringent legislation to hold intermediaries accountable and foster consumer-friendly practices.

Overall, the literature review yielded crucial insights into various aspects of life insurance and health insurance, encompassing the legal framework, industry trends, and consumer perspectives. This knowledge formed the foundation of the researcher's study and deepened their understanding of the complexities and challenges within the insurance sector.

Supreme Court, various High Courts, and the National Consumer Disputes Redressal Commission were thoroughly examined as part of the study. The researcher also analyzed the reports submitted by the Law Commission, which provided valuable insights into life insurance and the functioning of public sector undertakings, including their litigation policies and strategies.

The statement highlights the Report on Financial Sector Legislative Reforms Commission (FSLRC), which was presented to the Ministry in March 2013. This report presents a comprehensive set of recommendations for reforming the financial sector in India. Its primary objective is to streamline and modernize financial laws and regulations to enhance efficiency, transparency, and consumer protection.

One specific recommendation mentioned in the statement pertains to the conversion of statutory corporations, such as the Life Insurance Corporation of India and the State Bank of India, into ordinary companies registered under the Companies Act 1956. This proposal aims to align the governance and regulatory framework of these corporations with the provisions of the Companies Act. The intention is to introduce greater consistency, flexibility, and potentially improve accountability and performance.

However, it is essential to note that the implementation of such recommendations necessitates careful evaluation, analysis, and consultation with relevant stakeholders.

Any changes in the structure and functioning of statutory corporations should be thoroughly assessed for their potential impact on consumer interests, market stability, and the overall financial system.

For a comprehensive understanding of the FSLRC report and any subsequent developments or discussions related to its recommendations, it is advisable to refer to the original report itself and stay updated on any further developments in this area.

OBJECTIVES OF THE STUDY:

1. To evaluate the effectiveness of existing legal remedies available in civil courts, consumer forums, and ombudsman offices in resolving insurance disputes promptly.

2. To assess whether any modifications are needed in the current wording of insurance contracts to provide clearer understanding to policyholders.

3. To determine whether consumers receive adequate insurance coverage, timely services, and relevant information.

4. To examine the role of intermediaries in the insurance industry and address any unethical practices or misconduct.

5. To critically analyze the performance of the Insurance Regulatory Development Authority (IRDA) in light of the recommendations made in the FSLRC report.

METHODOLOGY AND SCOPE OF RESEARCH:

The research described in the statement adopts a comprehensive approach that combines both theoretical and practical aspects of the insurance market. It includes an

analysis of legal doctrines as well as practical considerations involving various stakeholders in insurance disputes, such as policyholders, agents, and advocates.

To gather data and test the hypotheses outlined in section 1.6, the researcher conducted personal interviews and distributed questionnaires. These methods aimed to assess the level of understanding and preferences of policyholders regarding insurance principles. Additionally, they sought to examine the interactions between agents and policyholders and the role of advocates representing claimants and beneficiaries.

For the study, three private insurance companies were selected: ING Vysya, PNB-Metlife, and SBI Life Insurance. The choice of ING Vysya and PNB-Metlife was based on their corporate offices being located in Bangalore. Furthermore, the inclusion of the Life Insurance Corporation of India, a public sector company, provided a comprehensive representation of the life insurance sector.

For the purpose of this study, three private insurance companies were selected as case studies: ING Vysya, PNB-Metlife, and SBI Life Insurance. The choice of these companies was based on their corporate offices being located in Bangalore, providing convenient access for the researcher. By including both private and public sector companies, represented by the Life Insurance Corporation of India, the study aimed to encompass a diverse range of insurance providers and capture the nuances of the life insurance sector.

The scope of the research extends to examining the existing legal remedies available in civil courts, consumer forums, and ombudsman offices, with a specific focus on their effectiveness and efficiency in resolving insurance disputes. Furthermore, the study analyzes the language and wording of insurance contracts to determine if any changes are necessary to enhance clarity for policyholders. It also assesses whether

consumers receive the necessary insurance coverage, services, and information in a timely manner.

Another important aspect of the research is the examination of the role played by intermediaries in the insurance industry. This includes evaluating their conduct, practices, and potential misconduct that may impact consumers. Additionally, the study critically analyzes the performance of the Insurance Regulatory Development Authority (IRDA) in light of the recommendations made in the Financial Sector Legislative Reforms Commission (FSLRC) report. This assessment aims to determine the effectiveness of the regulatory body in ensuring consumer protection and fostering a fair and transparent insurance market.

By employing a comprehensive research approach and focusing on specific objectives, this study intends to shed light on the challenges faced by insurance consumers and propose measures for improvement. The findings of this research have the potential to contribute to the enhancement of consumer protection and the development of a more efficient and consumer-friendly insurance industry.

To ensure geographical relevance, the interview questionnaire was circulated among insurance agents operating in Bangalore, Chennai, and Ernakulam, and responses were collected from advocates practicing in these three cities. A total of 225 agents, 150 advocates, and 100 policyholders were selected as participants in the study.

The selection of respondents followed a purposive sampling approach, aiming to include individuals from various Southern states. The number of respondents was determined based on resource availability, including time and logistical considerations.

To complement the research findings, statistical data from the websites of the Insurance Regulatory and Development Authority (IRDA), the governing body of the Insurance Council, and the Ministry of Finance, Consumer Affairs, as well as parliamentary debates, were accessed electronically. However, there might be limitations in accessing a larger number of case laws specifically related to the Life Insurance Corporation of India due to its extensive tenure compared to private companies. Additionally, cases involving private companies may not be as frequently heard in High Courts.

HYPOTHESES:

1. The responsibility of insurance companies and the government to create awareness about insurance at the grassroots level is insufficient.

2. There is a lack of comprehensive life and health insurance policies with clear and understandable terms and conditions.

3. Consumers face challenges in understanding the terms and conditions of insurance contracts, particularly regarding nomination and assignment.

4. Consumers are unwilling to provide all the necessary information, and intermediaries fail to communicate the relevance and importance of the information to be supplied.

5. Consumer Forums have not yielded the expected results, and confusion persists regarding whether the process is a summary trial or a regular trial, resulting in a wastage of time and money for consumers when disputes arise.

6. The existing insurance laws, regulations of the IRDA of India, and the Insurance Ombudsman are ineffective in protecting the interests of policyholders and consumers.

RESEARCH QUESTIONS:

1. Does the role played by the Union of India in protecting its citizens adequately address unexpected and unwanted calamities, including expenditure towards health coverage?

2. Do consumers obtain insurance for their actual needs, or are insurance products forced upon them through marketing techniques? Are the UN guidelines on consumer protection being practiced in India?

3. Is there a need for a dedicated law to regulate insurance intermediaries, similar to the provisions available for the Life Insurance Corporation of India? Can the possibility of enacting uniform legislation be explored?

4. How can the duty of good faith, which is essential for an insurance contract, be effectively enforced? Does the existing law require any amendments?

5. Is there a necessity to establish a separate tribunal for the insurance sector, apart from motor accident cases, as recommended in the 190th Law Commission report?

6. Should the proposed Insurance Laws (Amendment) Bill, 2008 be enacted, and should the government accept the recommendations put forth by the FLSRC?

Chapter II

DEVELOPMENT OF INSURANCE LAW IN UK AND USA

The concept of the ombudsman originated in Sweden in 1809 and is derived from a Scandinavian term meaning commissioner or officer. The ombudsman's primary responsibility is to investigate and report allegations against administration to the parliament.

In the realm of insurance, one of the fundamental principles guiding insurance companies is to provide financial security to policyholders in times of need. When individuals purchase insurance policies, they place their trust in the insurer, expecting their claims to be honored when they file a claim. Maintaining this trust is crucial both ethically and at the foundational level.

However, it is widely recognized that insurance companies, like any other businesses, have profit motives. Therefore, it is important to ensure that these profit motives do not hinder the fair and timely settlement of claims. In order to address this concern, the Indian government has established the institution of the Insurance Ombudsman, which aims to expedite the resolution of grievances between insurance buyers and insurers.

The Insurance Ombudsman in India has jurisdiction over both private and public insurance companies. Its existence provides a fair platform for all parties involved, instilling confidence in the system and allowing individuals to trust in the process and

benefit from the insurance sector. This setup benefits both policyholders and insurers, promoting optimal growth in the insurance industry.

The presence of an Insurance Ombudsman provides individuals with a means to address any concerns or disputes they may have with their insurers. This contributes to a transparent and customer-centric insurance environment.

HISTORY OF THE INSURANCE OMBUDSMAN SCHEME IN INDIA:

The introduction of the Insurance Ombudsman has created a separate and specialized mechanism for grievance redressal in the insurance sector, addressing the limitations of resolving disputes through Consumer Courts, Arbitration, or Civil Courts.

The success of the banking ombudsman scheme established by the Reserve Bank of India in 1995 in resolving customer complaints in the banking sector prompted the government to establish a similar system for the insurance sector. The government enacted the Redressal of Public Grievances Rules in 1998, under the powers granted by Section 114(1) of The Insurance Act, 1938, to establish the Insurance Ombudsman.

The main objective of the Insurance Ombudsman is to instill faith and confidence among the public and insured individuals by providing a speedy, cost-effective, impartial, and efficient resolution of grievances. Operating as a quasi-judicial body, the Insurance Ombudsman has jurisdiction over both public and private insurance companies. Importantly, there is no fee required for filing a complaint before the

Insurance Ombudsman, and only individual aggrieved insured individuals can file complaints against insurers.

Over time, amendments have been made to enhance the functioning of the Insurance Ombudsman system. In 2017, modifications were made to the Redressal of Public Grievances Rules, and Insurance Ombudsman Rules were introduced to further improve the resolution of policyholders' complaints. These amendments expanded the scope of complaints to include individuals, members of group policies, and MSMEs.

Furthermore, the advent of Information and Communication Technology (ICT) has facilitated online filing of complaints, allowing policyholders to conveniently lodge their grievances and track the progress of their complaints through online platforms.

Moreover, the scope of the ombudsman scheme has been expanded to include insurance brokers, agents, and other intermediaries. This means that the ombudsman can now issue awards against these intermediaries in cases where deficiencies in insurance services are identified. These developments have significantly enhanced the accessibility and comprehensiveness of the grievance redressal mechanism for policyholders in India.

QUALIFICATIONS OF AN INSURANCE OMBUDSMAN:

To be eligible for the position of an insurance ombudsman, the applicant must be between 55 and 65 years of age at the time of application. They should either be a member of the civil service or the All India Services of the Union, having held a post equivalent to that of a joint secretary in the Government of India. Alternatively, they

should have served in the insurance industry for a minimum of 25 years, holding a position no lower than one level below that of a director on a board. An insurance ombudsman serves a term of three years or until they reach the age of 70, whichever comes earlier. Reappointment is not permitted.

APPOINTMENT OF AN INSURANCE OMBUDSMAN:

The council of insurance ombudsman appoints an insurance ombudsman based on the recommendations of a selection committee. Presently, there are 17 ombudsmen functioning across India.

REMOVAL OF AN INSURANCE OMBUDSMAN:

An ombudsman can be removed from office during their term on grounds of gross misconduct. The term "gross misconduct" encompasses physical incapacity, unsoundness of mind, insolvency, conviction for an offense involving moral turpitude, engagement in any other paid employment, conflict of interest, or providing false information during the selection process by omitting material facts. The council for insurance ombudsman has the authority to remove an ombudsman for such reasons.

POWERS AND FUNCTIONS OF THE INSURANCE OMBUDSMAN:

1. The ombudsman receives and examines complaints or disputes from policyholders.

2. They determine the appropriate procedure to be followed in each case.

3. The ombudsman has the authority to settle disputes based on the facts presented, even without conducting formal hearings.

4. If a complaint lacks merit, the ombudsman may dismiss the case.

5. One of the key functions of the ombudsman is to make awards, providing resolutions to the disputes.

6. The ombudsman must act fairly and impartially, ensuring equitable outcomes.

7. In cases where the ombudsman has a personal interest in the subject matter, they should recuse themselves from deciding the case.

8. With the written consent of all parties involved, the ombudsman can act as a mediator and counselor in resolving disputes.

9. The central government or the Insurance Regulatory and Development Authority of India (IRDAI) can refer matters to the insurance ombudsman for resolution.

GROUNDS FOR COMPLAINTS BEFORE THE INSURANCE OMBUDSMAN:

1. Delay in settling claims beyond the specified time as per the regulations under the Insurance Regulatory and Development Authority of India Act, 1999.

2. Partial or total repudiation of claims by life insurers, general insurers, or health insurers.

3. Disputes concerning the premium paid or payable under an insurance policy.

4. Misrepresentation of policy terms and conditions mentioned in the policy document or contract.

5. Legal interpretation of insurance policies, particularly regarding claims.

6. Grievances related to policy servicing, including issues with insurers, agents, and intermediaries.

7. Issuance of life insurance policies, general insurance policies (including health insurance), which do not align with the proposal form submitted by the policyholder.

8. Non-issuance of insurance policies after receiving the premium in life insurance and general insurance, including health insurance.

9. Any other matters arising from violations of provisions outlined in the Insurance Act, 1938, or the regulations, circulars, guidelines, or instructions issued by the IRDAI, as well as the terms and conditions of the policy contract.

PROCEDURE FOR COMPLAINTS

If an individual has a grievance against an insurer, they, or their legal heirs, nominee, or assignee, may file a written complaint with the Insurance Ombudsman. The complaint should be submitted to the Ombudsman within the territorial jurisdiction where the branch or office of the insurer in question is located, or where the complainant resides.

The complaint must be in writing, signed by the complainant or their authorized representative, and provide clear details such as the complainant's name and address, the name of the insurer's branch or office being complained against, the facts supporting the complaint (supported by relevant documents), the extent of the loss suffered by the complainant, and the relief sought from the Insurance Ombudsman.

Before approaching the Insurance Ombudsman, the complainant must have taken the following steps:

1. The complainant should have submitted a written representation to the insurer mentioned in the complaint.

2. Either the insurer rejected the complaint, or the complainant did not receive a response within one month after the insurer received the representation.

3. If the complainant is unsatisfied with the insurer's response.

The complaint must be filed within one year:

1. From the date of the insurer's rejection of the representation, or

2. From the date of receipt of the insurer's decision if it is not satisfactory to the complainant, or

3. After one month has passed since sending the written representation if the insurer fails to provide a reply.

The Ombudsman has the authority to condone any delays, based on the circumstances presented. The insurer will be given an opportunity to object to the proposed condonation, and the Ombudsman will record the reasons for condoning the delay. If the delay is condoned, the date of condonation will be considered as the filing date of the complaint for further proceedings.

A complaint cannot be filed with the Insurance Ombudsman if the same subject matter is already being dealt with by a court, consumer forum, or arbitrator.

Following the 2021 amendment to the Insurance Ombudsman Rules 2017, the introduction of Information and Communication Technology (ICT) allows insured individuals to file complaints online without any fees. This amendment also enables tracking the status of the case and facilitates video conference hearings. These

changes aim to enhance the timeliness and cost-effectiveness of the grievance redressal mechanism.

AWARD UNDER INSURANCE OMBUDSMAN RULE

When a complaint brought before the Insurance Ombudsman cannot be resolved through mediation, the Ombudsman assumes the responsibility of issuing an award. This award is a formal decision that is made based on the arguments and evidence presented by both parties involved in the dispute.

The award, provided in writing, includes a clear explanation of the reasoning and factors considered by the Ombudsman in reaching the decision. It aims to provide transparency and ensure that all parties understand the basis for the award.

If the Ombudsman's award is in favor of the complainant, it specifies the compensation amount that the insurer is required to pay. However, the Ombudsman is bound by certain limitations. They cannot award compensation that exceeds the actual loss suffered by the complainant as a direct result of the cause of action. Additionally, the compensation, including any relevant expenses, cannot exceed a maximum of thirty lakhs rupees.

The Insurance Ombudsman is expected to work efficiently, and as such, they are required to finalize their findings and issue the award within a period of three months from the receipt of all necessary information and documents from the complainant.

Once the award has been issued, the Ombudsman sends a copy to both the complainant and the insurer named in the complaint. The insurer is then obligated to

comply with the award within thirty days of receiving it. Furthermore, they must inform the Ombudsman about their compliance with the award.

In cases where the complainant is entitled to receive compensation based on the Ombudsman's award, they are also entitled to receive interest. The rate of interest is determined by the regulations framed under the Insurance Regulatory and Development Authority of India Act, 1999. This interest accrues from the date the claim should have been settled under the applicable regulations until the actual date of payment based on the Ombudsman's award.

It's crucial to emphasize that the award issued by the Insurance Ombudsman is binding on the insurers. This ensures that the decisions made by the Ombudsman are enforceable, providing a sense of finality and resolution to the dispute.

PROVIDED THAT THE OMBUDSMAN SHALL INSURANCE OMBUDSMAN CASES

Case: Insurance Ombudsman (Bhubaneswar)

Facts:

In this case, the insurer alleged that the life assured had intentionally withheld crucial information regarding their health and pre-existing illnesses during the policy application.

Findings:

Upon examination, the insurer failed to provide concrete evidence that the life assured had serious illnesses prior to obtaining the insurance policy.

Decision:

As a result of the insufficient evidence provided by the insurer, the Ombudsman directed the insurer to settle the claim within one month from the receipt of the consent letter. This decision aimed to ensure that the complainant received the rightful compensation promptly.

Case: Insurance Ombudsman (Ahmedabad)

Facts:

In this particular case, the life assured had been extremely detailed and transparent about their health condition and habits during the policy application process. This resulted in additional medical reports being requested, and the insurer accepted the proposal with an additional premium.

Findings:

Unfortunately, the life assured passed away within ten months of the policy's inception. The insurer, however, repudiated the claim, alleging that the life assured had suppressed material facts during the application process. They based this decision on treatment certificates, prescriptions, letters from doctors and hospitals, and argued that all the diagnosis and treatment occurred after the acceptance of the policy.

The Ombudsman's examination of the evidence revealed that all the medical issues and treatments had commenced after seven days from the acceptance of the risk. This indicated that the deceased was unaware of their ailment at the time of applying for the policy.

Decision:

Considering the evidence and the timeline

Decision:

In the case handled by the Insurance Ombudsman (Chennai), the insurer claimed that the policyholder had failed to disclose a critical fact regarding their suffering from

Acute Lymphoblastic Leukaemia (ALL) with relapse on the proposal form. Consequently, the insurer repudiated the claim.

Findings:

Upon investigation, it was discovered that the deceased had been undergoing treatment for ALL since 2000 and had undergone Orchidectomy for relapse in 2003. However, this information was not disclosed in the proposal form submitted in December 2005.

Decision:

Clear medical evidence indicated that the deceased had been suffering from Leukaemia well before signing the insurance application. Therefore, the Ombudsman dismissed the complaint and upheld the insurer's decision.

Appeal against Ombudsman:

If a complainant is dissatisfied with the award issued by an Insurance Ombudsman, they have the right to pursue legal recourse against the insurance company through the regular legal process. However, it is important to note that the award of the Insurance Ombudsman is binding on the insurers.

INSURANCE OMBUDSMAN SCHEME IN OTHER COUNTRY

New Zealand:

The Insurance and Financial Service Ombudsman scheme, introduced in 1995, serves as a means to address consumer disputes with insurers. This independent and free scheme handles complaints from customers regarding various financial service providers, including loans, superannuation, health and life insurance, car insurance, contents insurance, house insurance, and investments.

One common dispute addressed by the scheme relates to alleged non-disclosure of material information to the insurer. Non-disclosure can result in the loss of insurance coverage. The scheme investigates such claims of non-disclosure, often involving independent underwriters who assess whether the undisclosed information would have impacted the decision to offer insurance or the terms of the policy. If the missing information would not have made a difference, it is not considered material non-disclosure.

Before approaching the Insurance and Financial Service Ombudsman, individuals must first go through their provider's internal dispute resolution process. If the matter cannot be resolved internally, a notice of deadlock should be requested. This notice is then provided to the Ombudsman as evidence that the internal process has been exhausted.

If the provider is a member of the scheme, complainants can complete the complaint form provided by the Ombudsman. Along with the notice of deadlock and supporting documents, the form is submitted by post or email.

Upon receiving a complaint, the Ombudsman obtains the complainant's file from the insurer and conducts any necessary inquiries. A Case Manager is assigned to investigate the complaint, discuss the issues with the parties involved, and seek expert assistance if required.

The Ombudsman may attempt to resolve the complaint through negotiation, mediation, or conciliation. The conciliators and mediators provided by the scheme ensure that any resolution reached is fair and reasonable.

If a resolution cannot be agreed upon, the Case Manager will make a decision regarding the outcome of the complaint. If both parties accept the outcome, it becomes final. However, either party can request a review of the outcome by the Ombudsman if new information or grounds exist. The Ombudsman will not review the matter solely because one party disagrees with the outcome.

If the complainant does not accept the outcome, they can escalate the dispute to the Disputes Tribunal or pursue legal action. The Ombudsman's award is binding on the insurer or financial services provider, and they must comply with the outcome. Throughout the investigation process, the complainant is entitled to be represented.

Every year, the Insurance and Financial Service Ombudsman responds to around 3000 complaints and resolves approximately 300 of them.

Australia:

The Australian Financial Complaint

Expansion:

Insurance Ombudsman Scheme in Other Countries:

New Zealand:

In New Zealand, the Insurance and Financial Service Ombudsman (IFSO) scheme was established in 1995 to provide redress for consumer disputes with insurers. This independent and free scheme handles complaints related to a wide range of financial service providers, including loans, superannuation, health and life insurance, car insurance, contents insurance, house insurance, and investments.

One common issue addressed by the IFSO scheme is alleged non-disclosure of material information to the insurer. Non-disclosure can have serious consequences, potentially leading to the loss of insurance coverage. When investigating claims of non-disclosure, the scheme often engages independent underwriters to assess whether the undisclosed information would have influenced the insurer's decision to provide

coverage or the terms of the policy. If the missing information would not have made a difference, it is deemed immaterial non-disclosure.

Before approaching the IFSO, complainants are required to exhaust their provider's internal dispute resolution process. If resolution cannot be reached internally, a notice of deadlock should be requested. This notice serves as evidence that the internal process has been completed and can be provided to the IFSO.

If the provider is a member of the IFSO scheme, complainants can submit a complaint form along with the notice of deadlock and any supporting documents to the IFSO by post or email.

Upon receiving a complaint, the IFSO obtains the complainant's file from the insurer and conducts additional inquiries as necessary. A Case Manager is assigned to investigate the complaint, engaging with the parties involved and seeking expert assistance when needed.

To resolve the complaint, the IFSO may employ negotiation, mediation, or conciliation techniques. The scheme provides conciliators and mediators to ensure that any resolution reached is fair and reasonable for all parties involved.

If a resolution cannot be achieved, the Case Manager will make a decision regarding the outcome of the complaint. If both parties accept the outcome, it becomes the final decision. However, if either party believes new information or grounds exist, they can request a review of the decision by the IFSO. It is important to note that the IFSO will not review the matter solely based on one party's disagreement with the outcome.

In cases where the complainant does not accept the decision, they have the option to escalate the dispute to the Disputes Tribunal or pursue legal action. The insurer or financial services provider is legally bound to comply with the IFSO's award, and the complainant has the right to be represented throughout the investigation process.

Each year, the IFSO receives and responds to approximately 3000 complaints, successfully resolving around 300 of them.

Australia:

In Australia, the Australian Financial Complaints Authority (AFCA) handles complaints that were previously managed by the Financial Ombudsman Service. AFCA considers complaints in various areas, including credit, finance, loans, insurance, banking deposits, payments, investments, and financial advice.

AFCA's role is to assist consumers and small businesses in reaching agreements with financial firms to resolve their complaints. The process and settlement of disputes within AFCA are similar to those in other countries' ombudsman schemes.

United Kingdom:

In the United Kingdom, the Financial Ombudsman Service (FOS) was established to address disputes between consumers and insurance companies. The FOS handles complaints regarding various insurance types, such as extended warranties, home insurance, medical insurance, motor insurance, pet insurance, and travel insurance.

Like other ombudsman schemes, there is no charge for using the FOS to settle disputes. The procedure for resolving complaints is generally similar to that of other countries.

Chapter – III

Development Of Insurance And Regulatory Frame Work Of Insurance In Indian Perspective.

Development Of Insurance

The advent of the industrial revolution in the Western world ushered in a transformative shift from an agrarian economy to a contemporary industrial landscape, accompanied by a novel form of societal vulnerability[13]. It was during this epoch that the foundations of the present-day insurance industry began to take shape, largely attributable to Britain's endeavor to experiment with and establish this novel concept[14]. While it may be perceived that insurance was an unfamiliar notion, historical evidence reveals that ancient India had already embraced certain aspects of this system, notably in the realm of maritime trade[15]. In ancient times, overseas traders practiced a rudimentary form of marine insurance, exemplifying the existence of early insurance practices. The joint family structure, an exceptional system of social organization that endures to this day, functioned as a remarkable mechanism of social insurance, safeguarding the welfare of each family member throughout their lifetime[4]. The Sanskrit term "Yogakshema," found in the Rigveda, connoted a form of insurance that was employed by the Aryans in India approximately 5000 years ago, if not earlier[16]. Manu, an ancient lawmaker, stipulated that a special fee should be levied on goods transported from one town to another to ensure their secure carriage until delivery to the recipient at the destination. Centuries later, Kautilya, in his Artha Shastra, also outlined various rules and regulations pertaining to insurance-like practices. "Manav Dharma Shastra" contained provisions for loan advancements, incorporating specified interest rates commensurate with the risks and duration of the borrowed funds[6]. Interestingly, the contract of insurance was an

[13] Societal vulnerability resulting from the shift to modern industrial activity during the industrial revolution in the West.

[14] The emergence and development of the insurance industry were significantly influenced by Britain's efforts during the industrial revolution

[15] Evidence suggests that ancient India had already practiced forms of insurance, particularly in maritime trade.

[16] The joint family system in India served as a means of social insurance, ensuring the well-being of family members

integral part of the contract of carriage, as evidenced by the codes of Manu, indicating that Indians had already contemplated principles akin to those of Average and Contribution[6]. In instances where cargo was lost due to the crew's negligence, the resulting loss was to be collectively borne, illustrating an early form of risk sharing[17]

When we delve into the annals of nations subjected to foreign dominion, it becomes apparent that profound transformations in cultural, economic, and social values occur, yielding both advantageous and detrimental effects on the governed populace. India, having experienced numerous invasions and rulers throughout its history, including the British colonial rule, still bears the imprints of their governance within its system, manifesting in various aspects even in contemporary times. Notably, the domains of law and medicine occupy prominent positions in this regard, and the sphere of insurance and its legal dimensions is no exception. The earliest recorded insurance company emerged on Bombay Island in the year 1793. In its initial stages, these insurance companies primarily catered to the insurance needs of Europeans and British nationals, as well as their family members. However, a pivotal moment arrived in December 1870 when seven determined individuals from Bombay, armed with a meager sum of seven rupees for preliminary expenses, conceived a plan to extend insurance coverage to the general public without the specter of financial ruin. Thus, the Bombay Mutual Life Assurance Society was established, marking its entry into the insurance landscape[18]. Over the subsequent half-century, a multitude of insurance companies sprouted, albeit some succumbed to mismanagement and were compelled to undergo liquidation. By the time the industry underwent nationalization in 1956, an extensive array of approximately 245 companies and societies were engaged in the business of life insurance.

The Role Of State under Constitution

Under Article 393, it is stipulated that the State should prioritize its policies to ensure that both men and women, as equal citizens, have the right to a sufficient means of sustenance. The Constitution recognizes that the right to livelihood encompasses more than mere physical

[17] Manu, Kautilya, and the ancient Indian texts "Manav Dharma Shastra" and "Artha Shastra" contained provisions and regulations related to insurance-like practices, including the concept of risk sharing and secure carriage of goods

[18] The impact of British colonial rule in India is discernible in various aspects, including the domains of law, medicine, and insurance. The emergence of the Bombay Mutual Life Assurance Society in 1870 signified a significant development in the insurance landscape, while subsequent years witnessed the establishment and closure of numerous insurance companies

survival; it encompasses the ability to lead a life of dignity and decency. The Union government has taken steps towards achieving these directives, but a significant disparity remains between the desired outcomes and the current achievements.

The fulfillment of these constitutional mandates can be pursued through various means, and undoubtedly, insurance is one such avenue to attain them. While the Union and State governments have initiated efforts in this regard, individual citizens also have a crucial role to play in striving for such a lifestyle. However, public awareness of these standards seems to be limited, as evident from the level of insurance penetration and density discussed earlier.

Another important aspect is the health of individuals and the creation of a collective environment conducive to well-being. The Constitution emphasizes that states should direct their policies towards safeguarding the health and strength of workers, both men and women. Additionally, it is equally vital to protect the rights of children and youth against exploitation, as well as moral and material abandonment. Material abandonment can occur when the primary breadwinner passes away or is excluded from the social system for various reasons. Such circumstances can be mitigated through individual life insurance coverage, which can provide compensation. The government can also play a crucial role by offering free or subsidized insurance coverage to needy citizens. While there are existing life insurance schemes that cater to agricultural workers and individuals below the poverty line, further enhancements are required. Recently, the Honorable Prime Minister announced an insurance scheme linked with bank accounts during his Independence Day address in 2014, which is expected to be implemented in the near future.

Regarding medical treatment, health insurance can alleviate financial dependence and mitigate economic deprivation to some extent. Both the Union Government and various State Governments are already providing assistance to citizens based on their financial capabilities, but significant improvements are still needed in these schemes.

During the inauguration of the Life Insurance Corporation of India on August 24, 1956, Pandit Jawaharlal Nehru, the first Prime Minister of India, conveyed his government's perspective with utmost clarity. He stated, "At the beginning of this year, the Government of India took a significant step by declaring that life insurance would henceforth be a State concern. Since then, numerous measures have been undertaken to implement this declaration. Life Insurance now assumes the status of a major State undertaking in India. It is a significant

stride in our journey towards a socialist society. Its objective is to serve both the individual and the State. The profit motive is eliminated, and the service motive becomes paramount"[19].

Dr. Sarvepalli Radhakrishnan, the Vice-President of India at the time, expressed his well wishes with the following words: "The Corporation will work towards the ideal of a welfare society, inspiring confidence in the people and assisting the Government in realizing its plans for the economic well-being of our country".

From these visionary statements made by these two esteemed statesmen, several key inferences can be drawn:

- The State has a clear role to play in realizing the development of a socialistic pattern of society, as envisioned in the constitution.
- Life insurance not only serves individuals during times of difficulty but also aids the State in achieving its vision of development by mobilizing savings and investments.
- Consumer protection and service assume a predominant role, surpassing the conventional profit motive typically associated with commercial endeavors.

Throughout this chapter and the subsequent ones, we will undertake a meticulous examination of the various aspects pertaining to the subject at hand. It is firmly believed by the researcher that Insurance can assume a significant role in safeguarding individuals from unforeseen and undesirable catastrophes. Article 41 of the Indian Constitution[20] encompasses the right to employment, education, and public assistance under specific circumstances. Moreover, the Universal Declaration of Human Rights in 1948[21] proclaims that every individual possesses the right to work, freedom of employment choice, fair working conditions, and protection against unemployment. The central focus of this research is the involvement of the state in Insurance. When a person is deprived of employment, they possess an active entitlement to compensation for the lost opportunity. However, it is not always feasible to consistently bear a substantial financial burden. Hence, the necessity for insurance arises, and unemployment insurance becomes an integral aspect of the State's

[19] Inferences drawn from the visionary statements of Pandit Jawaharlal Nehru and Dr. Sarvepalli Radhakrishnan during the inauguration of the Life Insurance Corporation of India

[20] Article 41 of the Indian Constitution establishes the right to work, education, and public assistance in certain circumstances (Source: Indian Constitution).

[21] The Universal Declaration of Human Rights (1948) affirms the right to work, freedom of employment choice, fair working conditions, and protection against unemployment (Source: Universal Declaration of Human Rights, 1948).

concept[22]. If unemployment occurs due to circumstances beyond an individual's control, the question of what safeguards exist naturally arises. Insurance can serve as one such measure to alleviate the resulting hardships. It is fascinating to observe that the framers of our Constitution engaged in extensive deliberations concerning the future livelihood of the community and the State's obligation in providing such sustenance for its citizens. Several significant articles within the Constitution, including Articles 39, 41, 42, and 47, outline the provisions for such benefits. These selected articles, supported by case law, have been chosen for study, as they contribute strength to the arguments presented. Nonetheless, it is important to note that these articles are not exhaustive in terms of the benefits conferred upon citizens. Given the limited scope of this research, they serve as a starting point for exploration[23].

In this research work, only a few articles have been discussed in detail from the Constitution of India. To provide a comprehensive understanding of their implications, the relevant articles are reproduced below:

1. Article 39: Certain principles of policy to be followed by the State[24]:

    - The State shall direct its policy towards ensuring that both men and women, as equal citizens, have the right to an adequate means of livelihood.
    - The ownership and control of the community's material resources should be distributed in a manner that serves the common good.
    - The economic system should not result in the concentration of wealth and means of production to the detriment of the common populace.
    - Equal pay for equal work should be ensured for both men and women.
    - The health and strength of workers, men and women, should not be abused, and children should not be compelled by economic necessity to engage in work unsuitable for their age or physical capabilities.
    - Adequate opportunities and facilities should be provided for children to develop in a healthy manner, under conditions of freedom and dignity.

[22] The concept of the State includes insurance against unemployment as an essential component (Source: Author).
[23] This study focuses on selected articles of the Indian Constitution, namely Articles 39, 41, 42, and 47, and is supplemented by relevant case law (Source: Author).
[24] Article 39 of the Constitution of India, 1950.

Childhood and youth should be safeguarded against exploitation, as well as moral and material abandonment.

2. Article 41: Right to work, education, and public assistance in certain cases[25].

 - The State, within its economic capacity and development, should make effective provisions to secure the right to work, education, and public assistance in situations of unemployment, old age, sickness, disablement, and other instances of undeserved want.
 - Just and humane conditions of work should be ensured.

"Maternity relief: The State is obligated to make provisions ensuring fair and compassionate working conditions and maternity relief[26].

The duty of the State to improve nutrition levels, raise the standard of living, and enhance public health is of utmost importance. The State considers the elevation of nutrition and living standards, along with the promotion of public health, as its primary responsibilities. Specifically, the State endeavors to prohibit the consumption of intoxicating drinks and harmful drugs, except for medicinal purposes, as they pose a threat to health[27].

It is crucial to note that these Articles are not included in Part III of the Constitution, which deals with Fundamental Rights. Instead, they are part of Part IV, known as Directive Principles of State Policy. Although certain rights may be construed as fundamental, it is not feasible for the State to enforce them directly, nor can the courts compel the government to implement such rights, such as the right to work or health. However, Article 37[28] emphasizes that while the courts cannot enforce the Directive Principles, they are fundamental to the governance of the country. Therefore, the principles outlined in Articles 39(a) and 41 should be regarded as equally fundamental in interpreting and understanding the meaning and content of fundamental rights.

Recognizing the importance of health and its impact on society, it is imperative to discuss the constitutional rights bestowed upon Indian citizens regarding health and how the State can fulfill its obligation to provide healthcare. This discussion sheds light on the significance of

[25] Article 41 of the Constitution of India, 1950
[26] Article 42 of the Constitution of India,1950
[27] Article 47, The Constitution of India, 1950.
[28] Article 37, The Constitution of India, 1950.

health insurance. The 82nd Amendment, through which Article 21A was introduced, highlights the application of these principles[16]."

"In order to establish the right to health as a fundamental right, an amendment similar to the one that made the right to education a fundamental right is necessary. The healthcare sector requires a regulated market that oversees hospitals, drugs, the quality and pricing of drugs, medical ethics, and medical negligence. Making the right to health a fundamental right, similar to the right to life, is crucial. This is important because the allocation and proper utilization of funds play a significant role in improving health. However, government investment in public healthcare has been slowly decreasing since 1990, as observed from data analysis. India is a signatory to the Universal Declaration of Human Rights, and our Constitution framers undoubtedly considered this when formulating fundamental rights and directive principles of state policy. To fulfill constitutional rights, including the right to health, a significant amount of resources is required.

Although the Constitution does not explicitly recognize the right to health as a fundamental right, it can be interpreted profitably that Article 14 and 21[29] guarantee health for all. Other rights are addressed under the Directive Principles of State Policy. It is the duty of the state to follow both in matters of administration and lawmaking. The right to health encompasses various aspects of life that contribute to the overall health of citizens. There are several laws that protect the health of citizens, such as The Pharmacy Act 1948, The Maternity Benefit Act 1965, The Pre-Natal Diagnostic Technique Act, The Prevention of Food Adulteration Act 1954, Consumer Protection Act 1986, The Mental Health Act 1987, and The Drugs and Cosmetics Act 1940. These acts were enacted in response to internal pressure rather than being driven by the country's actual needs. An analysis of the current healthcare system in India clearly indicates that the government.

"The responsibility for preventive health services has largely been assumed by the state, while curative care remains primarily in the hands of the private health sector. It is crucial to examine the dominant role of the private health sector, the resulting high healthcare expenditure, and the need for regulation and accountability within the private sector, all while

[29] Article 14, The Constitution of India, 1950."

strengthening market forces. This approach will safeguard consumers from various challenges and reduce their vulnerability. Furthermore, it is worth discussing significant judgments related to health issues.

Emergency healthcare has been recognized as a fundamental right, and the state has an obligation to provide medical facilities in such circumstances. Although private practitioners and hospitals have the right to select their patients, they are bound to extend their services to all in cases of emergencies and medical-legal situations. The Supreme Court has been highly critical of this matter, and consumer and civil courts have begun addressing the liability of doctors or hospitals for negligence in patient treatment. If necessary for the topic, this researcher will discuss this extensive subject in appropriate sections.

In the case of Confederation of Ex-serviceman v. Union of India[30], the Supreme Court observed that access to healthcare is not a fundamental right for ex-servicemen. The right to health is an important aspect of social justice, and it is the state's obligation to improve public health, as stated by the Supreme Court in Kirloskar v. Employees State Insurance Corporation of India[31]. In C.E.S.C v. Union of India[32], the apex court highlighted that the state may recognize health as a fundamental right and enact separate laws for its effective implementation. Assam is the only state that has passed a distinct health law. Let us briefly discuss the National Health Bill of 2009 and the O.N.G.C v. O.N.G.C Worker's Association case, where it was held that any statutory corporation meeting the criteria of a state entity..."

"Any instrumentality or agency, even if not categorized as a public utility undertaking, is obligated to act in accordance with the Directive Principles of State Policy[33][1]. In the case of N.D. Jayal v. Union of India[34][2], the Supreme Court held that the right to health is a fundamental right under Article 21 of the Constitution. The protection of this right is closely linked to a clean environment, as a clean and healthy environment itself is a fundamental right. This position was reaffirmed by the Court in M.C. Mehta v. Union of India[35][3]. Therefore, the impact of any project on human health cannot be ignored.

According to Article 41 of the Constitution, the state, within the limits of its economic capacity and development, must make effective provisions to secure the rights to work,

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[30] Confederation of Ex-serviceman v. Union of India, (2006) 8 SCC 399.
[31] Kirloskar v. Employees State Insurance Corporation of India, (1996) 2 SCC 682.
[32] C.E.S.C v. Union of India, (1995) 3 SCC 42.
[33] Referring to the principles laid out in the Directive Principles of State Policy in the Constitution of India.
[34] N.D. Jayal v. Union of India.
[35] M.C. Mehta v. Union of India.

education, and public assistance in cases of unemployment, old age, sickness, disablement, and other forms of undeserved want[364]. It is crucial to emphasize the concluding part of Article 41, which states 'old age, sickness, disablement, and other cases of undeserved want.' This is where health insurance plays a significant role. Most existing insurance policies do not provide coverage for individuals over 80 years of age, precisely when health insurance is highly necessary.

The state has a primary duty to elevate the level of nutrition, improve the standard of living of its people, and enhance public health. This duty includes striving for the prohibition of the consumption of intoxicating drinks and drugs that are harmful to health, except for medical purposes[37]. Therefore, it is the state's responsibility to provide and enhance public health as a primary duty."

The Supreme Court, in Ratlam Municipality v. Vardhichand[38], stated that the court should enforce this duty against a defaulting local authority and impose penalties as prescribed by law, regardless of the financial resources of such authority.

Although the Constitution does not explicitly include the right to health as a fundamental right, judicial interpretation has granted it that status[39]. In State of Punjab v. Ram Lubhaya Bagga[40], the Supreme Court emphasized that it is the primary duty of the state to ensure the health of its citizens. The state cannot disown its responsibility to provide medical facilities, as that would violate Article 21 of the Constitution. Government hospitals and health centers should be easily accessible to all sections of the population and maintain high standards of quality. However, the provision of medical facilities to citizens must be based on financial resources, and setting rates and scales can be justified.

In Paschim Bengal Ket Mazdoor Samiti v. State of West Bengal[41], the Supreme Court held that providing adequate medical facilities is an obligation undertaken by the government in a welfare state. The government fulfills this obligation by operating hospitals and health centers that offer care to those seeking facilities. Article 21 imposes an obligation on the state to protect the right to life of every individual. Thus, the failure to provide timely medical

[36] Article 41, THE CONSTITUTION OF INDIA, 1950.

[37] Article 47, THE CONSTITUTION OF INDIA, 1950.

[38] Ratlam Municipality v. Vardhichand.

[39] Judicial interpretation recognizing the right to health as a fundamental right.

[40] State of Punjab v. Ram Lubhaya Bagga.

[41] Paschim Bengal Ket Mazdoor Samiti v. State of West Bengal.

treatment to someone in need constitutes a violation of the right to life guaranteed under Article 21.

In State of Punjab v. Mohinder Singh Chawla[42], the government servant required specialized treatment that necessitated additional expenses. In such cases, the state government is obliged to bear the expenditure incurred by the government servant. The principle of free public healthcare remains a topic of debate."

According to the Supreme Court in the case of State Insurance Corporation[43], the Employee's State Insurance Act (ESI Act)[44] and Provident Fund Act (PF Act)[45] were enacted with noble intentions. The employer's contribution towards the premium for an employee's compulsory insurance under the ESI Act falls within Entries 23 and 24 of List III of the Seventh Schedule of the Constitution. Therefore, these contributions to provident funds or payments of other benefits to workers cannot be considered as taxes or fees. This social welfare legislation aligns with the Directive Principles of State Policy outlined in Articles 41, 42, and 43 of the Constitution.

The preamble of the Constitution, which promises to secure justice, social, economic, and political rights for all citizens, along with the Directive Principles of State Policy, mandates the state to establish a social order that promotes the welfare of the people. Specifically, Articles 41, 42, and 43 direct the state to make effective provisions for securing the right to work, education, and public assistance in cases of unemployment, old age, sickness, disability, and other situations of undeserved need.

In the case of D.S. Nakara v. Union of India[461], the Constitution Bench extensively discussed the significance of various Articles of the Constitution. They emphasized that Article 43(3) requires the state to strive for the full enjoyment of leisure, social, and cultural opportunities. The Supreme Court further noted that the term "socialist" was intentionally added to the Preamble of the Constitution through the Forty-Second Amendment Act of 1976. This addition aimed to achieve a socio-economic revolution that would eradicate poverty, ignorance, disease, and inequality of opportunity, thereby making the directive principles more comprehensive.

[42] State of Punjab v. Mohinder Singh Chawla.
[43] State Insurance Corporation.
[44] Employee's State Insurance Act (ESI Act).
[45] Provident Fund Act (PF Act).
[46] D.S. Nakara v. Union of India, 1983 AIR SC 130.

The fundamental framework of socialism aims to provide a decent standard of living for the working people and ensure security from birth to death. As individuals enter old age, the State is responsible for guaranteeing them a reasonably decent standard of living, access to medical assistance, freedom from want and fear, and enjoyable leisure. This alleviates the monotony and vulnerability associated with dependence in old age. Article 41 specifically directs the State to secure public assistance in cases of old age, sickness, and disability.

The Preamble directs the centers of power - Legislative, Executive, and Judiciary - to strive toward establishing such a socialist State. Although the transition from a feudal exploited slave society to a vibrant socialist welfare society is a long journey, every action taken by the State must be oriented and interpreted as a step toward the fulfillment of this goal. The objectives for which pensions are provided themselves promote the policy of establishing a welfare State, as pensions contribute to the socialist goal of lifelong security.

In the landmark case of Olga Tellis v. Bombay Municipal Corporation[47], the Supreme Court referred to Article 39(a) and Article 41 of the Constitution. The Court observed that if there is an obligation on the State to ensure adequate means of livelihood and the right to work, it would be pedantic to exclude the right to livelihood from the broader concept of the right to life[48].

Another significant judgment is the Bandhua Mukti Morcha v. Union of India[49], where the Supreme Court held that the right to live with human dignity, as enshrined in Article 21, draws its essence from the Directive Principles of State Policy. Particularly, clauses (e) and (f) of Article 39 and Articles 41 and 42 emphasize the protection of workers' health, prevention of abuse among children, provision of educational facilities, just and humane working conditions, maternity relief, and overall development in conditions of freedom and dignity. These essential requirements must be met to enable a person to live with human dignity, and neither the Central Government nor any State Government has the authority to deprive individuals of these basic essentials.

In L.I.C. of India v. Consumer Education & Research Centre[50], the Supreme Court held that Article 21, through an expansive interpretation of the right to life, extends it to encompass the

[47] Olga Tellis v. Bombay Municipal Corporation.
[48] Olga Tellis v. Bombay Municipal Corporation.
[49] Bandhua Mukti Morcha v. Union Of India.
[50] L.I.C. of India v. Consumer Education & Research Centre.

right to livelihood. Article 38 in the Directive Principles chapter also mandates the State to promote the welfare of the people by securing and protecting their livelihoods.

The principle of economic justice is inherent in all national institutions. The fundamental framework of the Constitution aims to ensure a decent standard of living for working individuals, providing security throughout their lives. A meaningful life, social security, and disability benefits are integral aspects of socio-economic justice, particularly for the middle class, lower-middle class, and all those who are capable of availing them. Life insurance coverage serves as protection against disability and provides economic support to dependents in the event of the insured's death, thereby ensuring social security and livelihood. Choosing an appropriate life insurance policy within the financial means of the insured to pay premiums is one of the social security measures envisaged by the Constitution, making the right to life and the right to livelihood meaningful and sustainable[51].

Based on the above discussion, it is evident that the Constitution of India grants its citizens the right to insurance, although not as a fundamental right. Therefore, it is essential for the State to take effective steps through proactive actions and decisions to enhance this facility. In this context, it is relevant to consider the implications of the Service Tax imposed on insurance premiums for contracts entered into after January 1, 2014. This taxation increases the cost of insurance. It is worth noting that the issue is not whether the State has the power to impose such a tax or not, but rather whether there is a need for such taxation as a social welfare measure, especially in the case of life insurance premiums[52].

Development and Important Legislation of Insurance in India

The Indian insurance industry has undergone a significant transformation since the early twentieth century. Initially, private insurance companies and societies misused funds, resulting in consumer suffering due to the arbitrary actions of individual companies[53]. Consequently, in 1956, the Union Government made the decision to nationalize the insurance

[51] Explanation of economic justice principles and the role of life insurance in providing social security based on the Constitution of India.

[52] Implications and considerations regarding the imposition of Service Tax on insurance premiums.

[53] Reference to the misuse of funds by private insurance companies and its impact on consumers.

industry, leading to the formation of the Life Insurance Corporation of India as a Statutory Corporation through an Act of Parliament[54].

The evolving global economic scenario, coupled with India's participation in various international covenants, compelled the Union Government to contemplate opening up the insurance industry and implementing reforms[55]. Recognizing the structural changes occurring in other sectors of the economy, the Government established a committee chaired by R.N. Malhotra, a former Governor of RBI. This committee recommended allowing the private sector's entry into the insurance industry, including the participation of foreign companies. Additionally, it proposed the establishment of an independent and autonomous regulatory body responsible for overseeing and supervising the insurance trade[56].

Following extensive discussions with various stakeholders, the government, through a resolution, constituted an interim regulatory authority to regulate the industry until comprehensive legislation was enacted. Subsequently, the Insurance Regulatory and Development Authority Bill was passed on 29.12.1999[57]. The fact that it took nearly five years for the authority to be formed since the Malhotra Committee's recommendation indicates the challenges and resistance encountered at different stages[58].

The Indian insurance industry underwent significant legislative changes with the enactment of key acts, namely the Insurance Corporation Act of 1956[59], the General Insurance Business (Nationalization) Act of 1972[60], and the Insurance Regulatory and Development Authority Act of 1999[61]. Prior to these acts, the business operated as a monopoly, primarily carried out by the Life Insurance Corporation (LIC) under the Life Insurance Corporation Act, which mandated stringent and continuous government supervision.

The General Agreement on Trade in Services (GATS), an agreement under the World Trade Organization (WTO), imposes obligations on member states to open their services industries to foreign players. In compliance with international pressure and political compulsions, the

[54] Explanation of the decision to nationalize the insurance industry and the establishment of the Life Insurance Corporation of India.
[55] Acknowledgment of the changing global economic scenario and India's international commitments as reasons for contemplating reforms in the insurance sector.
[56] Mention of the recommendations of the Malhotra Committee, including the entry of the private sector and foreign companies, as well as the proposal for an independent regulatory body.
[57] Reference to the enactment of the Insurance Regulatory and Development Authority Bill on 29.12.1999.
[58] Indication of the time taken for the formation of the authority, reflecting the challenges faced during the process.

[59] Reference to the Insurance Corporation Act of 1956.
[60] Mention of the General Insurance Business (Nationalization) Act of 1972.
[61]Reference to the Insurance Regulatory and Development Authority Act of 1999.

Indian insurance industry was opened to private players, ending the exclusive privilege held by the LIC in the life insurance sector. The amendment of the Life Insurance Corporation of India Act in 1956 by adding Section 30A marked the end of the monopolistic nature of the life insurance business, allowing Public Sector Insurance Corporations to compete with other insurance companies[62]. Similarly, with the addition of Section 24A to the General Insurance Business (Nationalization) Act of 1972, the exclusive privilege held by the General Insurance Corporation (GIC) came to an end in the general insurance sector[63].

Role of Insurance Regulatory Development Authority.

The primary objectives of the Insurance Regulatory and Development Authority (IRDA) are centered around promoting competition, enhancing customer satisfaction, and ensuring the financial security of the insurance market. The IRDA is a body corporate with perpetual succession and the authority to acquire, hold, and dispose of property, as well as to enter into contracts and engage in legal proceedings[64].

According to the IRDA Act, no individual or insurer can commence or continue any class of insurance business in India without obtaining a certificate of registration from the Authority. The certification ensures compliance and signifies authorization to operate within a specific class of insurance business[65]. The IRDA is responsible for regulating and promoting the orderly growth of the insurance and reinsurance sectors. It has the power to issue, renew, modify, withdraw, suspend, or cancel registration certificates.

In India, only public companies, cooperatives registered under relevant laws, and certain types of foreign corporate entities can engage in insurance business. Private companies are not permitted to carry out insurance operations in the country[66]. The Insurance Act mandates

[62] Reference to the amendment of the Life Insurance Corporation of India Act with the addition of Section 30A and the end of the life insurance business monopoly.
[63] Mention of the addition of Section 24A to the General Insurance Business (Nationalization) Act and the end of the exclusive privilege of the General Insurance Corporation.
[64] Reference to Section 3(2) of the IRDA Act, 1999.
[65] Reference to Section 3 of the Insurance Act, 1938.
[66] Reference to Section 2(c) of the Insurance Act, 1938.

that no person or insurer can initiate insurance business activities in India without obtaining the required certificate of registration from the IRDA[67].

The IRDA possesses extensive powers to gather information, conduct inspections, investigations, and inquiries, including audits of insurers, intermediaries, and other entities involved in the insurance sector. These measures are in place to ensure compliance with regulations and maintain the integrity of the insurance market.

The Insurance Regulatory and Development Authority (IRDA) holds a significant responsibility in safeguarding the interests of policyholders and ensuring their protection within the insurance business ecosystem[1]. This includes overseeing various aspects such as policy assignments, nominations, insurable interests, insurance claim settlements, policy surrender values, and other contractual terms and conditions.

The IRDA is empowered to establish the necessary qualifications, codes of conduct, and practical training requirements for intermediaries, insurance intermediaries, and agents. This ensures that these professionals possess the requisite knowledge and skills to effectively serve policyholders and carry out their duties. Additionally, the Authority has the authority to impose fees and charges to support the implementation of this Act and fulfill its objectives.

To safeguard the interests of policyholders, the IRDA has the power to regulate the investment of funds by insurance companies and establish solvency margin requirements. It also specifies the percentage of life insurance and general insurance business to be undertaken by insurers in rural or social sectors, thereby promoting inclusivity and socio-economic development.

It is worth noting that the regulatory powers of the Authority significantly reduce the role of the Union Government in controlling and regulating the insurance industry. However, the Authority is still obligated to provide returns, statements, and other relevant information to the Central Government as prescribed or directed, particularly regarding programs aimed at promoting and developing the insurance sector.

Furthermore, the IRDA is required to submit an annual report to the Central Government, providing a comprehensive account of its activities during the financial year, including initiatives undertaken for the promotion and development of the insurance industry. This ensures transparency and accountability in the functioning of the Authority.

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[67] Reference to Section 3(1) of the Insurance Act, 1938.

The Insurance Regulatory and Development Authority (IRDA) provides a comprehensive report on the development of the insurance industry in the previous financial year. Moreover, the Central Government has the authority to allocate funds to the Authority for the fulfillment of its objectives as deemed necessary. The Authority is obligated to adhere to the directions and policies set forth by the Central Government, and in specific circumstances defined in the Act, the Central Government can supersede the Authority.

The Authority has formulated more than fifty regulations, applicable to insurers, intermediaries, third-party administrators, and other entities within the insurance sector. These regulations, developed by the Authority since 2000, are also available in electronic format. It is important to note that these regulations have been established under the Authority's rule-making power. Throughout this research work, detailed discussions on various regulations are presented in the relevant sections.

Upon closer examination of the aforementioned provisions and regulations, it becomes apparent that the Authority operates as an extended arm of the Government. Although it possesses statutory authority, its autonomy is significantly restricted, and there exists a scope for the Central Government to exert its influence on the Authority. This observation aligns with the recommendations and findings put forth in the Report of the Financial Sector Legislative Reforms Commission, which was submitted to the government in March 2013[68]. The Commission acknowledged that the majority of the laws that financial firms encounter are in the form of regulations rather than primary legislation. Recognizing the specialized technical demands of the financial sector and the rapid pace of financial and technological advancements, the Commission emphasized the need to strike a balance between regulatory oversight and enabling innovation and development.

"The globally adopted framework involves Parliament enacting laws to establish financial regulators and set them in motion. These regulators, equipped with intricate market knowledge, then formulate regulations that evolve rapidly. The primary objective of financial law is to establish effective regulators and ensure their proper functioning[69].

The Financial Sector Legislative Reforms Commission has highlighted several advantages put forth by supporters of the regulatory regime. These include the ability to establish a specialized workforce with superior technical knowledge, assistance from modified human

[68] Reference to the report of the Financial Sector Legislative Reforms Commission
[69] Reference to the process of enacting laws and formulating regulations for financial regulators.

resources and streamlined processes compared to mainstream government departments, the flexibility to rapidly adapt regulations through specialized knowledge and industry observation, and the enhancement of legal certainty by ensuring regulatory approaches remain consistent despite political changes[70].

These observations hold true when considering the Insurance Regulatory and Development Authority. The current Chairman of the Authority, who has over three decades of experience in the insurance industry, previously served as the Chairman of the Life Insurance Corporation of India[71]. Additionally, as of May 16, 2014, two other members of the Authority, namely Member (Distribution) and Member (Non-Life), possess extensive experience in the insurance industry and have previously worked for public sector life insurance and general insurance corporations before joining the regulatory authority. Furthermore, the Authority emphasizes recruiting individuals with experience in the insurance sector and often engages personnel on a deputation basis to leverage their expertise.

"Their expertise and knowledge can be effectively harnessed. A noteworthy example of their swift response to market needs is the introduction of the IRDA (Standard Proposal Form for Life Insurance) Regulation in 2013, which was later deferred for further consultation and improvement in collaboration with stakeholders[72]. Due to the well-defined tenures outlined in Section 5 of the IRDA Act, the continuity of office for the chairperson and other members is not compromised by political changes. Moreover, their appointment does not rely on constitutional provisions that allow the appointing authority to remove them at their discretion. However, one unfavorable aspect that can be pointed out is that while discharging their regulatory duties, they may need to regulate their previous employers[73].

Another significant entity that plays a crucial role in the insurance business is the Life Insurance Council, established under the provisions of the Insurance Act, 1938[74]. This council operates through various sub-committees and consists of all insurance companies, encompassing the Life Insurance Council and the General Insurance Council. The council's objective is to contribute significantly and complementarily to the transformation of India's life insurance industry, fostering trustworthiness, profitability, and prosperity for individuals. Its functions include building a positive industry image, enhancing consumer confidence,

[70] Reference to the advantages stated by supporters of the regulatory regime.
[71] Reference to the Chairman's experience and previous position.
[72] Reference to the deferment and improvement of the IRDA (Standard Proposal Form for Life Insurance) Regulation.
[73] Reference to the regulatory duties of individuals and potential conflicts of interest with their previous employers.
[74] Reference to the establishment of the Life Insurance Council under the Insurance Act, 1938.

upholding high standards of ethics and governance, and raising awareness about the role and benefits of life insurance[75].

Despite these protective measures, there is a loophole that requires attention. To illustrate this, we can refer to a decision made by the Division Bench of the Delhi High Court in the case of M/S Radiant Overseas Pvt. Ltd. v. Insurance[76]."

"The regulatory decision discussed in this case is currently under appeal before the Supreme Court of India and is awaiting consideration[77]. The appellant, Radiant Overseas, filed a Writ Appeal before the Division Bench of the Delhi High Court, challenging the decision made by the Learned Single Judge. The challenge before the Learned Single Judge sought to quash the order issued by the IRDA on 30.04.2010, with an alternative request to direct the IRDA to register the petitioner under the relevant provisions of the Insurance Act, 1938, as amended by the IRDA Act, 1999[78]. The appellant's argument centered around the following facts:

Radiant Overseas entered into an Agreement on 20.09.1997 with Ukrinmedstrakh Insurance Company, which authorized the appellant to sell obligatory medical insurance policies to Indians intending to visit or travel to Ukraine. The appellant obtained necessary clearance from the Reserve Bank of India to collect insurance premiums and remit them to Ukrinmedstrakh or the Government of Ukraine. A similar arrangement was made with the Belorusian State Insurance Organization, Belgosstrakh, allowing the appellant to collect insurance premiums from visitors to Belarus. The appellant obtained permission from the Department of Economic Affairs, Insurance Division, Ministry of Finance, Government of India, for these activities.

Based on this background, the appellant began issuing certificates for emergency medical aid to individuals planning to visit Ukraine and Belarus, and the collected premiums were remitted to the respective governments of Ukraine and Belarus[79].

Initially, in 2003, a complaint was lodged with the IRDA against the company. Following an inquiry, the IRDA determined that the company had obtained the necessary permissions and subsequently closed the case[80]."

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[75] Description of the objectives and functions of the Life Insurance Council.

[76] Reference to the Division Bench decision of the Delhi High Court case.

[77] Reference to the regulatory decision under appeal before the Supreme Court of India.

[78] Description of the appeal and the appellant's requests to quash the IRDA's order and seek registration under the Insurance Act.

[79] Explanation of Radiant Overseas' issuance of emergency medical aid certificates and remittance of premiums to the governments of Ukraine and Belarus.

"The issue at hand was brought before the IRDA based on a court directive. Following an inquiry and after hearing the appellant, Radiant Overseas, the IRDA issued an order determining that Radiant Overseas was involved in insurance business. Under the authority granted by Section 14(1) of the IRDA Act, the IRDA directed Radiant Overseas to cease issuing, marketing, or selling insurance policies, collecting insurance premiums, and conducting any activity related to the insurance business. Non-compliance with the order would result in potential proceedings under the Insurance Act, the IRDA Act, and the relevant regulations.

Radiant Overseas argued that the medi-claim certificates issued by them had no effect within the territory of India and were active solely within the territories of Ukraine or Belarus. They contended that the provisions of the IRDA Act were not applicable to foreign insurance companies and that their activities fell outside the scope of the IRDA Act. However, the Learned Single Judge dismissed the petition, stating that the collection of premiums and the delivery of certificates within India constituted conducting insurance business in India on behalf of foreign insurance companies. The judge ruled that Radiant Overseas could not claim that their business operations were exempt from the Insurance Act or that they did not require a license from the IRDA.

Radiant Overseas appealed the decision to the Division Bench, which relied on the Supreme Court's judgment in British India Steam Navigation Co v. Shanmugavilas Cashew Industries[81]. The Division Bench held that Indian statutes are ineffective outside the jurisdiction of India. Moreover, they concluded that the business conducted by foreign insurance companies, like Radiant Overseas, within India would be subject to Indian laws and regulations[82]."

"The Division Bench reached a different interpretation regarding the nature of insurance business in India. They concluded that the act of issuing an insurance policy in India, even if the risks covered are incurred outside India and the premium is paid from India, does not constitute insurance business in India under the Insurance Act. According to the Bench, a mere ministerial act of issuing a contract in India, without it being operative and enforceable within India, cannot be considered as carrying on insurance business in India. The Bench also

[80] Mention of the complaint against Radiant Overseas and the subsequent closure of the case by the IRDA.

[81] Mention of the Division Bench relying on the Supreme Court's judgment in British India Steam Navigation Co v. Shanmugavilas Cashew Industries.

[82] Conclusion drawn by the Division Bench regarding the applicability of Indian laws to foreign insurance companies operating within India.

applied this interpretation to marine insurance, emphasizing that it equally applies to the insurance policy in question. In light of this interpretation, the Division Bench allowed the appeal, overturning both the order of the Learned Single Judge and the IRDA's order. They further held that the provisions invoked by the IRDA for exercising their powers were not applicable to the business or activity in question[83].

This case highlights the need for changes and amendments to the IRDA Act. Additionally, the presence of two distinct regulatory bodies, namely the RBI and the IRDA, exerting control over the same subject matter, creates challenges for businesses operating in the insurance industry[84]."

Essential Elements of Insurance Contract.

Chapter IV provides a comprehensive examination of the various terms and conditions that govern insurance policies. While a detailed analysis is presented there, this section will focus on the essential conditions that significantly impact consumers. Insurance, being a contract, is subject to the same principles that govern general contracts. Additionally, specific conditions such as insurable interest and utmost good faith also apply.

In the case of United India Insurance Company v. Manubhai Dharmasinhbhai Gajera, the Supreme Court emphasized that once the terms and conditions of an insurance contract are established, the protective shield over the policyholders' interests becomes fully operational. Insurance companies are prohibited from introducing any conditions, whether in their prospectus or policy, that are inconsistent with the terms and conditions approved by the Regulatory Authority[85]. This ensures that policyholders are safeguarded and not subjected to unfavorable conditions imposed by the insurance company.

Capacity to contract is another crucial aspect to consider. As stated in the case of Machima v. Usman Beary, a lunatic is completely incapable of entering into a contract, just like a minor

[83] Explanation of the Division Bench's interpretation of insurance business in India and their decision to allow the appeal, overturning previous orders.

[84] Discussion of the need for amendments to the IRDA Act and the challenges posed by dual regulation by the RBI and the IRDA.

[85] Explanation of the Supreme Court's ruling in the United India Insurance Company v. Manubhai Dharmasinhbhai Gajera case, highlighting the prohibition on derogatory conditions.

who lacks the legal capacity to do so. However, policies can be structured in a way that benefits individuals who cannot directly enter into a contract themselves. Minors, on the other hand, are not legally permitted to enter into insurance contracts. According to Indian law, a person of sound mind who is not disqualified by applicable laws can apply to insure their own life[86]. While in England and the USA, a minor's contract may be voidable rather than void, Indian law, as established in the case of Mahari Bibi v. Dhurmdas Ghose, considers a minor incompetent to contract[87]. Nevertheless, under the Guardians and Wards Act and the Hindu Minority and Guardians Act, a legal guardian is authorized to act in the best interests of the minor ward, including insuring their life, as it undoubtedly benefits the minor.

Accidental benefits are often included in life insurance policies, either through the payment of a nominal additional premium or as part of the standard coverage. However, to claim the accident benefit, the insured must provide satisfactory proof of the accident to the insurance company. Disputes may occasionally arise between the insured and the insurer when it comes to establishing the occurrence of the accident, thereby necessitating careful consideration and evidence.Instances of similar confrontations have also occurred in the English courts, as evidenced by the decision of Lord Macnaghten in the case of Fonton v. J Thorley & Co[88]. The concept of an accident has been defined as an unexpected or unintended event or mishap. However, disputes often arise regarding exclusion clauses in health insurance policies, which give rise to consumer conflicts. These terms are often not clearly communicated to the consumer, and certain medical conditions such as hypertension and diabetes have become common due to contemporary lifestyles. Nevertheless, the courts have consistently held that such health conditions are treatable disorders that can be managed through lifestyle changes and do not invalidate insurance contracts. The determination of whether to cover a specific risk lies within the purview of the underwriter and should not be encroached upon by legal professionals under the guise of social security or humanitarian considerations. It is important to note that for the industry to thrive, a fair and compassionate resolution of disputes should be reserved for exceptional cases rather than becoming the norm[89].

[86] Discussion of the capacity to contract for minors and individuals of sound mind.

[87] Reference to the case of Mahari Bibi v. Dhurmdas Ghose and its impact on the contractual competence of minors.

[88] Reference to the case of Fonton v. J Thorley & Co and Lord Macnaghten's views on accidents.

[89] Discussion of disputes arising from exclusion clauses in health insurance policies and the courts' perspective on treatable health conditions.

Consumer Protection in Insurance Laws.

Chapter VIII provides a detailed examination of the Consumer Protection Act of 1986, while also addressing the relevant provisions of the Insurance Act of 1938 concerning consumer protection. The Insurance Act is divided into five parts, covering provisions applicable to insurers, management, re-insurance, and more. It comprises a total of 123 sections, including repeals. The term "Life Insurance business" refers to the act of effecting insurance contracts on human life, which may include contracts guaranteeing the payment of money upon death (excluding death by accident) or the occurrence of any contingency dependent on human life. It also encompasses contracts that require premium payments for a term dependent on human life.

Furthermore, life insurance business includes the granting of disability, double or triple indemnity accident benefits, as long as they are specified in the insurance contract. It also encompasses the granting of annuities based on human life. However, the granting of superannuation allowances and annuities from specific funds applies exclusively to providing relief and support to individuals engaged in a particular profession, trade, employment, or their dependents. In the case of General Family Pension Fund v. The Commissioner of Income Tax[90], it was held that a company engaged in the business of granting terminable pensions or annuities dependent on human life for the benefit of subscribers or their nominees is considered an insurance business within the definition outlined in Section 2(11).

Additionally, the Insurance Act mandates that every insurer must undertake a specified percentage of life insurance business and general insurance business in the rural or social sector, as determined by the Authority and published in the Official Gazette. Another crucial provision that benefits the insured is the requirement for issuing notices as stipulated in Section 50 of the Insurance Act, 1938. However, the process of sending such notices involves various considerations, including costs and legal requirements, which will be discussed in later parts of this study. Lord Mansfield's observation in Stevenson v. Snov[91] highlights that equity implies a condition wherein insurers should not receive the price for running a risk if

[90] Reference to the case of General Family Pension Fund v. The Commissioner of Income Tax.
[91] Reference to Lord Mansfield's observation in Stevenson v. Snov regarding equity and running a risk

they have not taken any. Furthermore, in Kettlewell v. Refuge Assurance, it was emphasized that if the fraud originates from the insurer's side, the insured is entitled to a refund of the premium paid.

Fraudulent representations and breaches of good faith by insurers can give rise to claims for a refund of the premium by the insured. This principle is applicable not only in the Indian context but also in other jurisdictions. In India, the Indian Contract Act provides the insured with the right to claim a refund of the premium by avoiding the contract[92][1]. However, in the case of insurance contracts, this principle is often contested on the grounds that once the risk has been covered for a specific period, the question of refunding the premium does not arise. These aspects require further detailed examination to ensure the protection of innocent consumers and address their interests promptly.

[92] Reference to the provision in the Indian Contract Act that allows the insured to claim a refund of the premium by avoiding the contract.

CHAPTER-IV.

Critical Legal Analysis OfLife And Health Insurance Policies.

Introduction:

Many insurance policyholders are unaware that when they purchase an insurance policy, they are entering into a contractual agreement with the insurer. While policyholders may perceive it as simply buying a product and expecting financial support in case of contingencies, it is important to recognize that an insurance policy is a legally binding contract. This raises the question of whether the terms and conditions of the policy align with the policyholder's expectations.

In the case of Gen. Assce. Society Ltd v. Chandmull Jain[93], the Supreme Court considered the issue of whether an insurance contract can include a clause allowing the parties to cancel the policy. The Court ruled that such a clause was not illegal and emphasized that the court's role is to interpret the words of the contract as expressed by the parties, rather than creating a new contract on their behalf.

[93]Gen. Assce. Society Ltd v. Chandmull Jain, AIR 1966 SC 1644.

However, contracts must adhere to the legal framework and not violate public policy, as stated in Section 23[94] of the Indian Contract Act, 1872. The concept of public policy is not precisely defined in the Act. In Central Inland Water Transport Corporation v. BrojonathGanguly,[95] the Supreme Court clarified that public policy refers to matters concerning the public good and public interest, and it can evolve over time. The court may extend existing principles or even establish new ones based on public conscience and the principles underlying the Fundamental Rights and Directive Principles enshrined in the Indian Constitution.

To ensure consumer protection, the Insurance Regulatory and Development Authority of India (IRDA)[96] now mandates that the terms and conditions of insurance policies and products be approved. The IRDA regulations cover various aspects of insurance products, including product structure, minimum death benefit, surrender, policy term, premium-paying term, and commission. While complying with these regulations may pose initial challenges for insurance companies when introducing new products, it ultimately benefits consumers. It is crucial for insurers and regulators to approach policy formulation with an open mind, as this can prevent post-contractual disputes and unnecessary litigation.

Elements of Life Insurance and Health Insurance Contract

Nature of Insurance Contract:

[94]Section 23 of the Indian Contract Act, 1872: The consideration or object of an agreement is lawful unless it is forbidden by law, fraudulent, involves injury to another person or property, or is considered immoral or opposed to public policy.

[95]Central Inland Water Transport Corporation v. BrojonathGanguly, AIR 1986 SC 1571.

[96]IRDA (Non-Linked Insurance Products) Regulation, 2013.

Insurance law operates within the framework of contract law. Before delving into the legal principles and terms, it is important to understand the procedures involved in issuing policies and settling claims. In India, life insurance policies are predominantly sold through intermediaries rather than directly by insurance companies. Individual agents, brokers, and banks play a crucial role in the sales process, with individual agents contributing significantly to the overall sales.

When an individual wishes to purchase an insurance policy, they are required to submit a proposal form containing their financial and personal details. The insurance company evaluates the information provided in the proposal form[97], which forms the basis of the contract, to decide whether to accept or reject the risk. In some cases, additional medical tests may be required to assess the risk. If the desired insurance product is not available, the prospect may be offered an alternative product. Depending on the prospect's health conditions, the risk may be postponed or covered with an extra premium. Once the proposal form is scrutinized, the insurance company makes a decision regarding acceptance or non-acceptance.

After the proposal is accepted, the policyholder is required to pay the premium, which serves as the consideration for the contract. The premium payable is determined in advance and documented in a public premium table. In life insurance contracts, the decision to cover the risk is made only at the office of the insurance company. Unlike general insurance contracts, there is no practice of issuing a cover note to provide immediate coverage. Instead, the amount paid initially, along with the proposal, is held in deposit. Upon acceptance of the risk, this deposit is converted into the first premium, marking the completion of the contract. The insured is then identified as the policyholder, and the insurance company as the insurer.

[97]Sec. 2(d), IRDA(Protection of Policyholders' Interest) Regulations,2002.

The Insurance Regulatory and Development Authority of India (IRDA) has established regulations, such as the IRDA (Protection of Policyholders' Interest) Regulations, 2002,[98] which outline the rights of policyholders. These regulations ensure that policyholders have the opportunity to review the terms and conditions of the policy and, if necessary, apply for its cancellation within a specified period. The regulations also provide guidelines for the claim procedure in lifeinsurance policies.

Insurance contracts adhere to general contractual principles, including offer, acceptance, performance, and breach, with additional aspects such as warranty and utmost good faith. In an insurance contract, there are two parties involved: the insurer and the insured. The insured pays the premium, which serves as the consideration for coverage against unforeseen destruction or damage. The occurrence of the insured event must be uncertain and beyond the control of both parties. The insured cannot profit from the occurrence of the insured event in an insurance contract.

[98]Reg.6(2) while forwarding the policy to the insured, the insurer shall inform by the letter forwarding the policy that he has a period of 15 days from the date of receipt of the policy document to review the terms and conditions of the policy and where the insured disagrees to any of those terms or conditions

A contract of insurance must satisfy all the elements required for a typical contract, such as offer, acceptance, consideration, and an intention to form legal relations. However, insurance contracts also have specific conditions to be met, including the principle of utmost good faith (uberrimaefidei). Unlike in normal contracts, where both parties have the opportunity to negotiate terms and conditions, in insurance contracts, the terms are typically prepared by the insurance company, and the insured party must either accept them entirely or reject them entirely. This type of contract is known as a contract of adhesion. Furthermore, while the general rule in business contracts is "caveat emptor" (let the buyer beware), insurance contracts operate under the principle of "uberrimaefidei" (utmost good faith). A contract of insurance is also conditional, with the insured required to pay regular premiums, and the claim amount being paid upon the occurrence of the insured event.

Life insurance policies are categorized as contingency policies, as they pay a specified sum of money upon the occurrence of a given event

Basis of contract clause.

The basis of contract clause first appeared in the reported case of Duckett v. Williams [99]. In most insurance companies, the proposal form includes a declaration stating that the statements made in the form are true and correct, and they will form the basis of the contract. Any false or incorrect statements can give the insurance company the right to void the contract and forfeit the amount paid. Therefore, it is crucial to discuss the basis of the contract clause. One important aspect is the disclosure of health and habits, for which the proposed insured is obligated to provide accurate information. Insurance companies rely on complete details to accurately assess the risk. The second issue is whether the insurance company can contest the insured's health condition when the company's doctor has examined and provided a report. The law is not clear on this matter. The Kerala High Court, in the case of P. Sarojam v. LIC of India [100], observed that the mere fact that the medical officers of the insurance corporation have certified the life assured as healthy is not of significant consequence. "It is important to note that the doctor's report only records what the proposer says." This is a common feature in insurance contracts.

<u>Warranty In Insurance Contract</u>.

A warranty in an insurance contract refers to a term that, if breached, allows the insurer to terminate the insurance from the time of the breach. It should be noted that a term should not be considered a warranty unless there are clear indications that both parties intended it to have that effect. The interpretation of each contract must be based on the specific terms outlined within it. In insurance, a warranty is a term whose breach releases the insurer from liability. It is defined as a stipulation that is secondary to the main purpose of the contract and its violation only leads to a claim for damages rather than the complete avoidance of the contract.

[99] Duckettv.Williams,(1834)2.C&M318.
[100] AIR 1980 KER 201

A condition may be treated as a warranty, but not vice versa. While the term "warranty" is used in insurance without explicitly mentioning "conditions," they are often used interchangeably. It has been observed that a warranty is a statement or representation that forms the basis of the contract, and the entire validity of the contract depends on its truth or falsity. A warranty is typically in writing and included in the policy. Inserting a stipulation or representation into the contract does not automatically make it a warranty.

However, if any statement is untrue, it will be deemed a warranty, and the insurance company will not be liable. The interpretation of warranties was historically more lenient in life insurance compared to marine insurance. The judgment in Ross v. Bradshaw[101] established that a warranty of good health does not mean a person is completely free from any potential disorder. Instead, it means they are insurable as long as they do not currently have a sickness that would render the contract unequal.

Over time, the interpretation of warranties became more rigid, ignoring the context of equal bargaining power in contract negotiations. The courts held that a written paper folded in the policy or a slip of paper attached to it did not necessarily become a strict warranty. However, in Dausons Ltd v. Bonnin[102], misstatements in the proposal form, regardless of their materiality, were treated as warranties and grounds for policy avoidance. In Thompson v. Weems[103], the House of Lords ruled that the declaration at the end of the proposal form creates a warranty based on the form's contents.

[101]Ross v Bradshaw, 1 Bl.W.312.
[102]Dausons Ltd v. Bonnin
[103]Thompson v. Weems.

Although the intention behind the rule was good, some insurers exploited it by forcing the assured to treat every representation, regardless of its significance, as a warranty. This practice was deemed unfair to the assured. To avoid a contract based on a warranty, the only requirement is to prove that the representation is false, regardless of its materiality. Whether the represented fact is important or trivial does not matter. In most life and health insurance proposal forms, there is typically a question asking about the present state of health, to which the answer is generally "GOOD." However, the relevance of this question becomes significant when considered in relation to other questions.

Insurable Interest

Insurable interest is a crucial requirement for a valid insurance contract. Without insurable interest, the contract would be void as it would be considered a wager. Although a life insurance policy involves risk and speculation, it is not inherently a wagering contract. The purpose of an insurance contract is to mitigate existing risks, whereas a wagering contract creates risk through the contract itself[104]. Insurable interest is what distinguishes an insurance policy from a mere wager. The primary reason for the requirement of insurable interest is to prevent wagers and, to a lesser extent, eliminate the temptation to cause the loss being insured against. In the case of Carlill v. Carbolic Smoke Ball Co Ltd[105], a wager was defined as a contract in which neither party has an interest apart from the contract itself.

[104]Jones v. Provincial Ins Co, (1857) 3 CB (NS) 65.
[105]Carlill v. Carbolic Smoke Ball Co Ltd, (1892) 2QB 484,490.

The legal requirement for insurable interest in the United Kingdom is derived from the Life Assurance Act 1774[106]. This act prohibits insurance without interest, not only on life but also on any other event. The law mandates that the insured must have an insurable interest in the life of the assured. In England, this requirement applies to all types of insurance except marine insurance and insurance of goods and merchandise. Insurable interest can be based on family relationships or financial relationships. For example, a debtor has an interest in the life of a creditor, a father has an insurable interest in the life of his children (but not vice versa), and a husband has an interest in the life of his wife. These family relations are based on natural love and affection. In England, a husband can insure the life of his wife, and vice versa, without having to prove a pecuniary interest in the insured's life. However, this rule does not extend to the insurance of their children.

In the United States, insurable interest is recognized for all individuals who have a close relationship or affinity with the insured's life, as long as they have a non-pecuniary interest in the continuation of that life based on natural affection. The concept of insurable interest between husband and wife was also recognized in the United States. The requirement of insurable interest must exist at the time of entering into the insurance contract, as established in Barnes v. London, Edinburgh & Glasgow Life Insurance Co. The concept was further explained in Dalby v. India & London Life Assurance Co, stating that insurable interest does not need to exist at the time of the insured's death, as it is a matter of construction of the Life Assurance Act 1771.

[106]Malcolm A.Clarke, The Law of Contracts, Lloyds of London Press Ltd(2009).

In India, although no specific statute requires insurable interest, it is enforced as a matter of public policy. Certain dependent relatives have a legal right to maintenance in India. For example, a Hindu wife is entitled to be maintained by her husband during his lifetime and by her father-in-law after his death, according to Sections 18 and 19 of the Hindu Adoption and Maintenance Act 1956. A Hindu is also obligated to maintain their legitimate or illegitimate children and aged or infirm parents according to Section 20. The heirs of a deceased Hindu are bound to maintain certain dependents mentioned in Section 21 of the same Act. Insurable interest can arise from natural love and affection or economic relationships. A father has an insurable interest in the life of his children, and similarly, a husband has an interest in the life of his wife, and vice versa.

Standard Form of Contracts.

Standard form contracts are commonly used in insurance contracts, just like in general contracts. The basic principles and elements of general contracts, such as agreement, offer, acceptance, and consideration, apply to insurance contracts as well. However, there are certain special terminologies and concepts that are unique to insurance contracts, including standard form and contract of adhesion.

In a contract of insurance, one party agrees to compensate or indemnify another party for a potential loss that may occur due to uncertain events beyond their control. The insurer undertakes the obligation to pay a sum of money or provide an equivalent benefit if the specified event covered by the insurance policy takes place. In most types of insurance contracts, except for life insurance, the principle of indemnity applies. This means that the insurer's liability is limited to the actual loss suffered by the insured or the amount of risk covered, whichever is less.

To illustrate this principle, let's consider an example of a medical or health insurance policy. If the sum assured for a surgery or treatment is Rs 2 lakhs, the claim will be limited to that amount, even if the insured has incurred expenses exceeding Rs 2 lakhs. Similarly, if the insured has spent Rs 1 lakh on medical treatment, the insurance company will only reimburse Rs 1 lakh, not the entire sum assured. The purpose of insurance is not to generate profits but to provide indemnification for actual losses incurred by the insured. Therefore, the insured must demonstrate the actual loss before seeking reimbursement from the insurer.

The policy document plays a crucial role in insurance contracts. It represents the terms and conditions of the insurance policy and outlines the rights, responsibilities, and coverage provided to the insured. The importance and content of the policy document are visually depicted below to emphasize the significance of the insurance policy bond.

A policy document in insurance contracts typically includes a policy schedule, which contains details such as the policy number, date of commencement, premium amount, and mode of payment. It also outlines the benefits payable under the policy, commonly referred to as standard provisions. These provisions may include information about surrender, availability of loans, provisions regarding assignment and nomination, and other relevant details. Additionally, there are specific conditions applicable to certain policies, such as those taken under the Married Woman's Property Act or pension plans, which are known as special policy conditions.

In a contract of insurance, it is essential to clearly define the risk, duration of coverage, consideration for covering the risk, and the sum assured, which represents the quantum of risk covered. The insurance policy serves as the exclusive record of the insurance contract, and both parties are bound by its terms. It has been established through legal precedent, as in the case of Arterial Caravans Ltd. v. Yorkshire Insurance Co. Ltd.[107], that when the insured possesses the policy document for an extended period and makes a claim under it, they cannot disaffirm a part of the contract.

[107]Arterial Caravans Ltd. V. Yorkshire Insurance Co. Ltd, (1973) 1 Lloyd's Rep. 169

In today's globalized economy and with increased consumerism, numerous contracts are entered into daily without individuals' full knowledge. Examples include parking lot and theater tickets, purchase slips, and online shopping agreements. These contracts often take the form of standard form contracts. Similarly, in the insurance industry, a large number of policies are issued, and many of them have identical terms and conditions. This makes the use of standard form contracts highly convenient. Insurance contracts are one type of standard contract drafted by the insurer and simply accepted by the insured. The need for standard form contracts arises due to the requirements of mass production and a large consumer base.

Standard form contracts do not typically involve bargaining, negotiation, or meaningful consent. They are often printed documents containing terms explicitly or implicitly presented by one party (the proffering party) to the other party (the adhering party) on a take-it-or-leave-it basis. This model is closer to the imposition of one party's will than a mutually agreed arrangement and is sometimes described as private legislation or a contract of adhesion. The adhering party signs and accepts the contract, usually entering into several such contracts.

The advantages of standard form contracts primarily favor the proffering party[108]:

They reduce transaction costs for the proffering party, especially when engaging in many repeat transactions, thus increasing profits.

[108] MindyChen-Wishart,ContractLaw,366-367(4th edn.,2012).

They allow for centralized control over contractual arrangements in large operations, maintaining consistency across sales staff.

They enable the proffering party to set terms that benefit itself, such as narrowing its own obligations, increasing the adhering party's obligations, and strengthening remedies while excluding or limiting claims against it.

However, standard form contracts also present certain dangers:

Lack of comprehension by the adhering party.

Lack of negotiability due to an imbalance of bargaining power.

Substantive unfairness due to a significant imbalance in the rights and obligations of the parties, often to the detriment of the adhering party.

In contract law, the legislative process traditionally involved lawmakers creating laws, and executive officials enforcing them. However, in contract law, the legislature now only creates a portion of the relevant law and delegates the responsibility for the rest to other departments. As a result, the two contracting parties no longer agree to all the private laws that will govern them. Instead, they agree only to a small portion, delegating to one party (typically the seller of a product or service) the power to determine the remaining terms. Insurance consumers, for instance, typically agree only to aspects such as prices, coverage limits, and general risks to be covered, while leaving all other provisions to the insurer to set unilaterally in the form of a policy. Individuals subject to these private laws without their consent require protection, which judicial review can provide. However, judicial review is only available if private lawmaking is recognized as a form of lawmaking. Standard form contracts are commonly enforced on the assumption that they are contracts, even when recipients may not reasonably be expected to read or understand them fully. Insurance policyholders, for example, often receive their policies only after making the purchase, and even then, only a small fraction of insured individuals read and understand the policy. Nonetheless, insurance policies are effectively treated as contracts.

In an insurance policy, which represents a contract between the insurer and the insured, strict interpretation is necessary to determine the extent of the insurer's liability. The insured cannot claim more than what is covered by the insurance policy. In cases such as Oriental Insurance Co. Ltd. v. Sony Cheriyan[109], the Supreme Court held that the insurer is not liable if the insured transports articles that are not permitted under the rules. The insurance policy only covers non-hazardous articles permissible under the law, and in this case, hazardous articles were transported. Therefore, the insurer was not held liable for the loss related to the transportation of those articles.

[109] OrientalInsuranceCo.Ltd.v.SonyCheriyan,AIR1999SC3252

In cases involving a large number of contracts, it becomes impractical to draft a separate contract for each individual consumer. As a result, printed forms of contracts are commonly used, which contain standard terms and conditions, often in small and difficult-to-understand print. These terms typically exclude many liabilities, leaving little room for negotiation, particularly in the case of life insurance. In such situations, consumers are left with the choice of either accepting the contract in its entirety or rejecting it completely. There is no middle ground where they can accept certain terms and reject others.

An illustrative case is Thornton v. Shoe Lane Parking Ltd[110], where the claimant was injured in a car park partly due to the defendant's negligence. The claimant received a ticket upon entering the car park after paying at a machine. The ticket stated that the parking contract was subject to terms and conditions displayed inside the car park, one of which excluded liability for personal injuries arising from negligence. The court had to determine whether this term was incorporated into the contract, i.e., whether the defendant had brought it to the claimant's attention before or at the time the contract was made. It was held that the machine itself constituted the offer, and the acceptance occurred when the money was inserted into the machine. Since the ticket was issued after the acceptance took place, the clause excluding liability was not incorporated into the contract.

[110]Thornton v. Shoe Lane Parking Ltd, (1971) All ER 686 C.A.

In L'Estrange v Graucob Ltd[111], a case involving the purchase of a cigarette vending machine, Mrs. L signed an agreement without reading it. The agreement contained a clause excluding liability for any defects in the machine. The machine turned out to be entirely defective. The court ruled that when a document containing contractual terms is signed, the party who signs it is bound by those terms in the absence of fraud or misrepresentation, regardless of whether they have read the document or not. Such contracts are known as contracts of adhesion, where the individual has no choice but to accept the terms without negotiation. However, individuals need protection against potential exploitation inherent in such contracts. In Henderson v. Stevenson, it was observed that the person delivering a document must provide adequate notice of the printed terms and conditions to the offeree. Failure to do so may result in the acceptor not being bound by the terms, and notice of the terms should be given before or after the time of the contract.

General Terms and Conditions of Life Insurance Policy.

It is a legal requirement that the written terms of any contract, including insurance policies, should be expressed in clear and understandable language. In cases of doubt or ambiguity, the interpretation that is favorable to the consumer should prevail. What may be clear to insurers and courts may not be easily understood by policyholders. If a word has a technical meaning in criminal law, it is generally interpreted in the same way in an insurance contract.

[111] L 'Estrange v Graucob Ltd, (1934) 2 KB 394.

While there is no legal compulsion for anyone to obtain an insurance policy if they are not satisfied with the terms and conditions, in practice, policies are almost always recorded in writing. This is done as a necessary precaution due to the significance and complexity of the policy terms. In both the United Kingdom and India, it is essential for insurance policies to document all the relevant terms, such as the parties involved, commencement date, premium, and sum assured. These requirements are mandated by regulations, such as those set by the Insurance Regulatory and Development Authority (IRDA) in India.

In summary, insurance contracts must be written in plain and intelligible language, with a preference for consumer-friendly interpretations in case of doubt. While not legally mandated, written policies are the norm due to the importance and complexity of the terms. Compliance with these requirements is essential both in the United Kingdom and India.[112]

Interpretation of policy conditions.

The interpretation of policy conditions in insurance contracts follows established rules of construction that have been developed over time. In any contract, it is essential to determine the clear intention of the parties involved. Disputes may arise regarding the meaning of specific words related to the coverage provided, the applicability of particular clauses to specific events, and apparent contradictions within the same policy.

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[112] IRDA(ProtectionofPolicyholder'sInterests)Regulations,2002.

Effective communication, whether verbal or written, relies on using simple and understandable language that can be comprehended by all parties involved. When the language becomes complex, it becomes necessary for someone to step in and interpret and explain the true meaning of the words. This is also applicable to the terms and conditions of insurance contracts. The intention of the parties is expressed through the words of the policy. However, contractual disputes often arise because the parties have different interpretations of what was intended and the meaning of the contractual provisions.

Courts follow a three-step methodology to interpret contracts. Firstly, they imply the intent of the parties from the expressed provisions of the contract. If the expressed provisions do not fully and unambiguously convey the intent of the parties, additional evidence of their objective intent may be considered. If there is uncertainty in the meaning of the contract language, courts refer to primary canons of interpretation. Contracts are interpreted in a manner consistent with their overall purpose, giving reasonable, lawful, and effective meaning to all the terms. If uncertainty still persists, courts resort to secondary standards of interpretation, construing contract language against the party that drafted the contract. In some cases, other maxims may be invoked as judicial tie breakers.

The meaning of a word in an insurance policy is generally understood to be the interpretation that an ordinary person of normal intelligence would place upon it. Terms of legal art are given their technical meaning. For example, the word "not" in an insurance policy may be interpreted according to its special meaning in criminal law. A well-drafted insurance contract should be clear and easily understood by policyholders and courts, who determine the sense in which the words should be understood by the policyholder in case of a dispute. Courts consider the intention of the parties when interpreting the contract.[113]

To achieve clarity and understanding, certain rules are followed in interpreting insurance contracts, similar to other types of contracts. These rules include:

[113]KennethS.Wollner E-book,HowtoDraftandinterpretInsurancePolicy.

1. Words are understood in their ordinary sense as comprehended by ordinary people. Words are not interpreted in isolation but within the context of the contract and with the aid of traditional canons of interpretation.

2. In the event of inconsistency in the ordinary meaning of words in different parts of the contract, the meaning that best reflects the intention of the parties is preferred.

3. If it appears that words have been used in a special sense, either as previously defined by courts or within a particular commercial context, they will be interpreted accordingly.

4. If, despite applying the previous rules, the meaning of the words remains unclear, the words may be read with reference to any evidence of the purpose of the contract that is not apparent from the contract itself. Additionally, the words may be construed contra proferentem, meaning against the insurer and liberally in favor of the policyholder.

These rules help ensure that insurance contracts are interpreted in a manner that aligns with the parties' intentions and provides reasonable protection to policyholders.

Rules constituting words and phrases.

The National Commission, in the case of Reliance Life Insurance Co. Ltd v. Madhavacharya[114], emphasized that insurance contracts are to be strictly construed to determine the extent of the insurer's liability. It cautioned against relying solely on the meaning of a word without considering the context in which it appears.

One important rule of construction in insurance policies is the gusdem genesis rule. According to this rule, when general words are connected with specific words, they should be interpreted as being limited to the same category or class as the specific words. Similarly, when general words follow a list of specific items, the scope of the general words is confined to the items listed.

Previous interpretation.

[114]RelianceLifeInsuranceCo.Ltdv.Madhavacharya,RP.NO211/2009,NCDRCdated2.2.2010.

In interpreting phrases or forms of words in insurance policies, previous court decisions play a significant role. However, it is important to consider the context in which those decisions were made. The construction of a clause in a policy cannot be considered "precisely similar" to another clause unless the context is the same. Words should always be interpreted in their specific context, and a difference in context can provide valid grounds for disagreeing with a previous decision, even if the same words are used in the current policy under consideration.

While drafting insurance contracts, insurers anticipate that certain words will have specific meanings based on the background and intention of the drafter. Standardized language is used with the expectation that once a court has interpreted and assigned a meaning to those words, other courts will follow the same interpretation.

Overall, the interpretation of insurance policy terms involves a careful analysis of context, previous court decisions, and the intention behind the use of specific words.

Ordinary Meaning.

The ordinary and popular sense of words is presumed to be the appropriate interpretation in insurance contracts. This presumption arises from the expectation that reasonable individuals would use words and phrases in their commonly understood and accepted meanings. Therefore, insurance policies should be construed in accordance with sound commercial principles and good business sense to ensure that their provisions are applied in a fair and sensible manner.

When a clause in a policy is ambiguous, and multiple readings are possible, the interpretation that produces a fairer result should be accepted. In the case of Hooper v. Accidental Death Insurance Co, an interesting issue arose where a solicitor was insured under an accident policy that promised to pay him a weekly sum if he suffered an injury "as wholly to disable him from following his usual business, occupation, or pursuits." The insurer argued that the solicitor was not wholly disabled, taking the words "as wholly to disable" at face value. However, the court held that when considering the clause as a whole, the meaning was that the insured should be disabled from conducting their usual business in the normal manner. Therefore, a reasonable construction of the clause prevailed.

In summary, the ordinary meaning of words is given weight in interpreting insurance policies, and a fair and reasonable interpretation is preferred, taking into account the context and purpose of the policy.

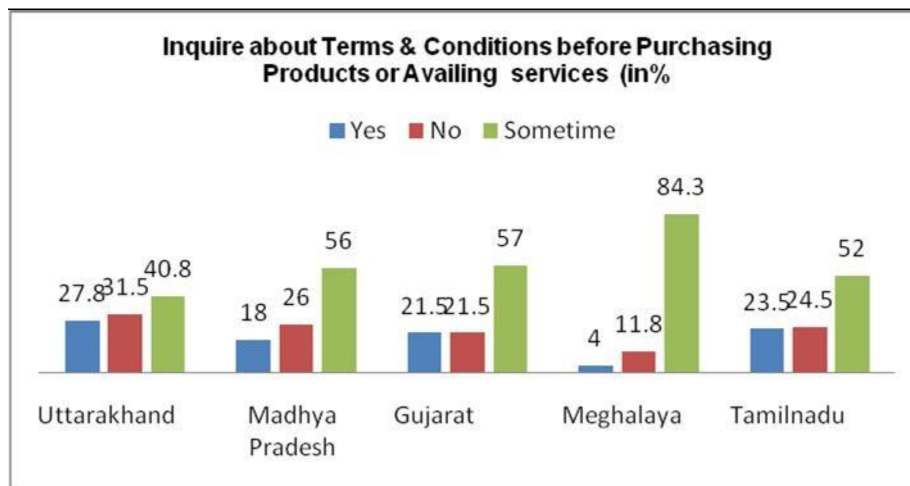
SpecificLifeInsurancePolicyconditions

Let's take a look at some common and standard conditions in consumer contracts and how they have impacted consumers, as well as the perspective taken by the judiciary. Before delving into the legal aspects, it's worth examining whether consumers inquire about the terms and conditions of goods or services before entering into transactions.

According to an Empirical Study conducted by the Center for Consumer Studies at IIPA, New Delhi, it was found that a significant portion of consumers did not make any inquiries about the terms and conditions (58%). Only 23.1% of respondents made inquiries sometimes, and a mere 19% made frequent inquiries. This study encompassed both goods and services, including insurance.

It is important to note these findings as they shed light on consumer behavior and their level of awareness regarding the terms and conditions associated with the products or services they purchase. Understanding consumer behavior in this regard is crucial when evaluating the impact and effectiveness of standard conditions in contracts.

Revival of lapsed policy:



In the case of a long-term life insurance contract, there is a possibility that the policyholder may be unable to pay the premium, resulting in the policy lapsing and the loss of coverage. To address this situation, insurance companies often include a clause in the policy allowing for the revival of a lapsed policy upon meeting certain requirements. These requirements typically include a declaration of good health, payment of the overdue premium with interest, and sometimes a medical report. When a policy is revived, no new policy document is issued, and the existing terms and conditions of the policy are reinstated, binding both parties. If adverse medical conditions are discovered during the revival process, the premium amount or term may be adjusted by mutual consent. It is important to note that a lapsed policy can only be revived during the lifetime of the insured individual, and the insurer has the right to decide whether or not to revive the policy.

Suicide clause:

A crucial provision in many insurance policies is the suicide clause, which states that the insurer does not cover death resulting from suicide within a specified period, usually one year from the date of policy issuance. Understanding the various dates associated with the policy is essential when interpreting the suicide clause. These dates include the date of commencement, date of policy, and date of proposal. The date of proposal refers to the date when the policy request is made through a proposal form, and upon completing the necessary formalities, the policy is issued with a specific date of issue. Disputes can arise due to differing interpretations and wordings of these dates among insurance companies.[115]

[115] LICofIndia&Anrv.DharamVirAnand, AIR1984SC1014.

It is common for insurance companies to exclude suicide risk during the first year of coverage to prevent individuals from obtaining insurance with the intention of committing suicide. Some companies may return the premium paid, while others may forfeit it. There is no standardized language for this contract clause, leading to disputes. Additionally, in cases where an accidental death benefit is included in the policy, death due to suicide is typically not considered an accident, and no additional payment is made.

Determining whether a death was a suicide or due to other causes can be challenging, particularly in the absence of a post-mortem examination. This can lead to disputes between insurers and the heirs of the deceased insured, especially in cases of deaths resulting from snake bites, ingestion of poisonous substances, accidents involving stoves, etc. There is a legal presumption that a person will not take their own life, and the question of suicide versus other causes of death is often left to the decision of a jury. Similar circumstances exist in India, emphasizing the need for an efficient system to gather accurate information, reducing claim settlement delays and unnecessary litigation.

Civil Death:

It is surprising that life insurance policies do not specify the procedure to be followed in the event of a person going missing during the policy term. This point pertains specifically to the insurance policy itself and not the court procedure for declaring a person legally dead. The interested parties must inform the insurance company that the life assured is missing and continue to keep the policy in force by paying the premiums until a competent court declares civil death. It is crucial to address this issue and include provisions on the policy document itself to avoid any confusion. A Supreme Court case provides an example highlighting this issue. In the case of Life Insurance Corporation of India v. Anuradha[116], the Corporation rejected the claim of the policyholder on the grounds of policy lapse due to non-payment of premiums.

The Supreme Court noted that in order to successfully claim benefits under an insurance policy, the policy must have been kept active through timely premium payments until the claim was made. The court upheld the decision of the insurance corporation to deny the claim and stated that the claimants were entitled only to the paid-up value of the policies. Importantly, the Supreme Court made parting remarks suggesting that regions or states affected by insurgency face uncertainty in life, and that the Life Insurance Corporation, being a social welfare institution, should consider devising policies tailored to the needs of individuals and families in such areas. In cases where the insured individual suddenly disappears or becomes untraceable, the beneficiaries or nominees may not even be aware of the existence of the insurance policy, the status of premium payments, or the obligations to keep the policy active. Thus, insurance policies with terms and conditions suitable for people living in insurgency-affected areas need to be developed and promoted.

Drowning:

[116]Life Insurance Corporation of India v. Anuradha, AIR 2004 SC 2070.

Death caused by drowning is generally considered accidental, even if it is not the result of violent external means. Drowning is presumed to be an accident. If the insurer wants to argue that the assured committed suicide or that the drowning was caused by a disease such as apoplexy or cramp, it is their responsibility to provide evidence of how the assured died. The fact that the personal representatives do not allow a post-mortem examination to be conducted does not necessarily discharge the burden of proof. In India, drowning is also considered an accident, but proof is often required, which can lead to disputes since such deaths are not typically registered as unnatural deaths. When a claim is made for the Accident Benefit, proof is demanded by the insurance company, which can result in litigation. There is no uniform procedure or mandatory requirement for registering deaths due to unnatural circumstances.[117]

Murder:

In cases of murder, the death benefit is paid, but disputes can arise when determining payment for the Accident Benefit. This depends on the specific facts of each case. In an unreported case, K. Sarojamma v. LIC of India[118], which was taken up to the Supreme Court, it was held that intentional murder is not considered an accident according to the policy conditions. The District Forum Anantapur allowed the complaint filed by the wife of the deceased life assured, considering murder as an accident. However, the State Commission and the National Consumer Disputes Redressal Commission (NCDRC) upheld the decision that intentional murder cannot be considered an accidental death within the meaning of the policy conditions.

[117]BallanfinevEmployer'sIns.Co.ofGreatBritainLtd(1893)21R.305.

[118]K.Sarojammav.LICofIndia,SLP28575of2011, October31,2011(SupremeCourtofIndia).

Death from Poison or Inhaling Gas:

If the assured mistakenly takes poison instead of medicine and recovers, there is no basis for making a claim. However, if the assured dies after taking poison, two situations must be distinguished. In a case (Re United London and Scottish Insurance Co), the claim was rejected based on an exception clause excluding death or disablement caused directly or indirectly by anything swallowed, administered, or inhaled. It was held that the assured, who was accidentally asphyxiated, could not recover. Additionally, if the policy requires bodily injury, the mere inhalation of poisonous fumes will not enable the assured to make a claim. In cases where a disease falls within the exception clause and causes an accident resulting in injury or death, the injury or death is usually considered to be caused by the accident rather than the disease. In Indian jurisdiction, similar judgments have been made on these points.[119]

Surgical Operation and Medical Treatment:

[119] ReUnitedLondonandScottishInsuranceCo, [1915]2Ch:167

If the insured undergoes an operation necessitated by their health condition and dies as a result of the surgery due to unforeseeable causes beyond the control of the surgeon or attending doctors, the accident benefit claim must be honored as it is a bona fide accident. If there is an explicit exception for death resulting from surgical treatment, and the insured suffers an accidental injury requiring an operation, the exception will not apply if the insured dies during a skillfully performed operation, even if the death is directly due to the operation and not the original injury. In LIC of India v. Narender Singh[120], the question arose whether the negligent act of a doctor resulting in the immediate death of the patient constitutes an accident. The State Commission and the National Commission held that it amounted to an accident. The National Commission maintained that the insured died during an operation caused by outward, violent, and visible means, and therefore, the insurance corporation could not be exempted from its liability to pay the accidental benefits.

Exposure to Natural Elements:

If the assured sustains an injury due to conflict with the ordinary forces of nature while engaged in their regular work or leisure activities, that injury is not considered accidental. The Supreme Court of the United States ruled that sunstroke was not covered by insurance against death "through external violent and accidental means." It was held that death from sunstroke resulting from exposure to heat on board a ship was not covered by a policy insuring against "injury caused by accident." If the exposure itself had been accidentally caused, such as by a shipwreck, then the resulting sunstroke might have been considered an injury by accident. However, since the injury was sustained in the normal course of the insured's work, it could not be deemed accidental.

[120] LICofIndiav.NarenderSingh,RPNO2056of 2012,July2,2012(NCDRC).

Grace Period and Payment of Premiums:

Insurance policies typically include a grace period for premium payment. This grace period allows policyholders additional time to pay their premiums without the policy lapsing. In India, the standard grace period is one month or not less than 30 days for yearly, half-yearly, or quarterly premiums, and 15 days for monthly premiums. After the grace period expires, if the premium remains unpaid, the policy will lapse.

A specific case that involved the interpretation of a grace period clause was LIC of India v Mani Ram[121]. In this case, Condition 2 of the Life Insurance Corporation of India policy stated that a grace period of one month (not less than 30 days) would be allowed for payment of yearly, half-yearly, or quarterly premiums, and 15 days for monthly premiums. If death occurs within this grace period and before the payment of the premium due, the policy remains valid. The sum assured is paid after deducting the premium due and any unpaid premiums falling due before the next policy anniversary. However, if the premium is not paid before the expiry of the grace period, the policy lapses.

[121]LICofIndiavManiRam,2005AIRSC3349.

The Supreme Court, while upholding the condition, emphasized the importance of considering all the terms and conditions of the policy and giving effect to them. Accepting the argument that contradicted the grace period clause would render the last part of Condition 2 redundant and inoperative. The court stated that a document cannot be construed in a manner that goes against its intended meaning. In the specific case, as the premium was due on April 28, 1996, and was not paid until May 28, 1996, the policy lapsed, and nothing became payable under the policy.

Guaranteed Surrender Value:

The Insurance Act itself provides for the surrender of a policy[122]. According to this provision, if all premiums have been paid for at least three consecutive years in the case of a policy issued by an insurer or five years in the case of a policy issued by a provident society, the policy acquires a guaranteed surrender value. The guaranteed surrender value includes any subsisting bonus already attached to the policy.

When a policy has acquired a surrender value, it does not lapse due to the non-payment of further premiums. Instead, it is kept alive to the extent of the paid-up sum insured. However, a policy kept alive as a paid-up policy is not entitled to participate in any profits declared after the conversion of the policy. The paid-up policy retains its value, but it no longer benefits from future profits.

[122]Sec. 113, The Insurance Act, 1938.

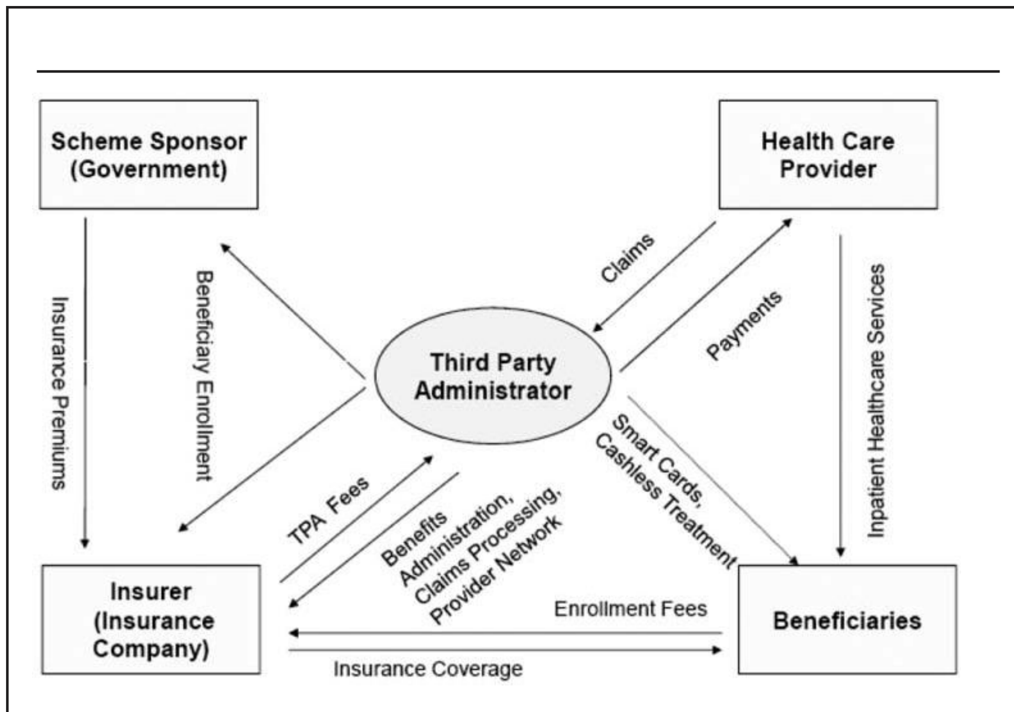
It's important to note that surrendering a policy and receiving the surrender value is a voluntary action taken by the policyholder and may have financial implications. The surrender value is typically lower than the total premiums paid, and surrendering the policy terminates all future benefits and coverage.

India has implemented various models of health insurance, each with its own financing source and organizational structure. Two notable examples are the National Health Insurance Scheme (RSBY) and the Community-Based Health Insurance (CBHI) program known as Yeshasvini.

The National Health Insurance Scheme (RSBY) was launched in 2007 with the objective of safeguarding unorganized sector workers below the poverty line from significant healthcare expenses related to hospitalization. This scheme is sponsored by both the central and state governments. The state governments enter into contracts with insurance companies to administer and manage the scheme.

On the other hand, the CBHI program, Yeshasvini, operates on a community-based approach. It relies on multiple agencies for its operations and financing. The government of Karnataka provides partial premium subsidies, the Karnataka State Cooperative Department handles marketing, cooperative societies enroll members, cooperative banks assist in premium collection, and a third-party administrator (TPA) administers the scheme. Yeshasvini predominantly utilizes a network of over 150 private hospitals across the state of Karnataka, selected based on their compliance with quality-of-care standards evaluated by the TPA.

Both RSBY and Yeshasvini have their unique characteristics, strengths, and challenges in terms of achieving health insurance objectives. It's important to note that there is no universally recognized "gold standard" model of health insurance, and different countries adopt diverse approaches based on their specific contexts and priorities.



The National Health Insurance Scheme (RSBY) in India provides a benefits package that primarily covers hospitalization and surgical services. It also includes outpatient procedures, pre and post-hospitalization expenses, a transport allowance, and maternity expenses. Beneficiaries of RSBY have access to a network of private hospitals without any additional fees. The selection and evaluation of these hospitals are done by a third-party administrator (TPA) appointed by the insurer, based on quality-of-care standards.

To subsidize premiums, the central government contributes significant resources, and state governments also bear a portion of the premium costs. Beneficiaries pay a nominal registration fee, and any administrative costs not covered by premiums are typically borne by the state government. The administration of the scheme is often outsourced to a TPA, which handles tasks such as authorizing hospitalizations and surgeries, processing claims, and maintaining a register of members. In states where a TPA is not utilized, the insurer assumes all the responsibilities of a TPA.

In the case of the Community-Based Health Insurance (CBHI) program Yeshasvini, operations and financing involve multiple agencies. The government of Karnataka provides partial premium subsidies, the Karnataka State Cooperative Department handles marketing, cooperative societies enroll members, cooperative banks assist in premium collection, and a TPA administers the scheme. Yeshasvini primarily relies on a network of over 150 private hospitals in Karnataka, selected through a quality-of-care evaluation conducted by the TPA. The TPA is responsible for authorizing surgeries, processing claims, and maintaining a register of members. Yeshasvini has received government subsidies every year since its inception and aims to become financially viable and self-sustaining with increased premium contributions from beneficiaries.

In Germany and Belgium, the prevailing health insurance systems are social health insurance schemes. These schemes are statutory programs financed primarily through contributions based on wages and income levels. They are mandatory for specific categories of workers and their employers. Examples of social health insurance schemes in India include the Employees State Insurance Schemes, the Central Government Health Scheme, and the Ex-servicemen's Contributory Health Scheme. The funds allocated to these schemes are dedicated to healthcare and cannot be used for other purposes. Mandatory participation in these schemes helps avoid adverse selection and ensures broader coverage. These schemes also continue to provide coverage after retirement when the need for care is often greater. Contributions to social health insurance schemes are based on income rather than healthcare needs, promoting equity among members. Vietnam's social health insurance has achieved significant coverage of its population.

Private health insurance has advantages such as promoting equity as everyone contributes to the scheme, stimulating investment and innovation in the healthcare sector, and improving the quality and efficiency of public healthcare systems. However, disadvantages of private insurance include the denial of high-cost treatments and the loss of medical coverage for those who do not opt for private insurance. In countries like India, where the public healthcare system faces challenges such as poor management, low service quality, weak financing, and limited responsiveness to patients' needs, the development of health insurance can potentially bring improvements to the public healthcare sector.

The private health sector in India has experienced unregulated growth, lacking effective guidance regarding location, scope of practice, and pricing. However, if private health insurance is developed in a systematic and planned manner, it can lead to improved government expenditure on secondary and tertiary care. The middle class and upper middle class income groups can benefit from private insurance, provided there is effective market regulation and adherence to professional ethics. Health insurance can take various forms, including community-based or non-community-based schemes. For the upper and middle-income groups, a combination of social insurance and private voluntary insurance may be more suitable[123].

To facilitate the development of private health insurance, the government's role should involve establishing an independent regulator to monitor and streamline the health sector. Community-based health insurance can be extended through non-governmental organizations (NGOs), which are well aware of local realities and can design schemes tailored to specific populations, thereby avoiding adverse selection. Non-profit organizations, such as NGOs involved in community-based health insurance, play a significant role, even in market economies like the United States. It is essential to ensure a level playing field in the open insurance market, allowing every company to operate according to its business model, while recognizing the special status of public sector companies or corporations.

[123](World Bank 2002).Quoted in the workingpaper 123, Health Insurance for the poor in India by Rajeev Ahuja March 2004.ICRIER.

Most health insurance schemes in India primarily cover inpatient care, leaving outpatient care largely uncovered. The success of health insurance depends on the availability of healthcare services in rural and remote areas, where facilities are often lacking. Existing health insurance schemes, such as the Central Government Health Scheme, Employees State Insurance Scheme, and NGO/voluntary sector schemes, are mandatory but have not grown as expected. Mediclaim policies offered by general insurance companies and certain policies offered by the Life Insurance Corporation of India dominate the market. Private insurance companies have also entered the sector since liberalization, and foreign insurers are attracted to India's untapped insurance market.

The settlement of health insurance claims can be done through cashless or reimbursement methods. Cashless settlement standardizes medical procedures and hospitalization expenses, but it may lead to unnecessary tests. Reimbursement requires policyholders to pay upfront, and hospitals may avoid unnecessary expenses as the extent of reimbursement is uncertain. Some life insurance companies have introduced health insurance products, and general insurance companies offer health insurance as well, but significant improvements are needed in product design and market sensitization. Issues such as disallowed claims and poor customer service during the reimbursement process are crucial for insurance marketing.

The healthcare sector was recognized as an industry in 1986, leading to liberalized import rules for medical equipment. This encouraged medical professionals to provide better care and diagnosis, although costs also increased. Until the passage of the Insurance Regulatory and Development Authority (IRDA) Act in 2001, health insurance in India was primarily offered by public sector general insurance companies. With the entry of private players, healthcare costs have been affected. The IRDA has formulated a standard health insurance policy, and the success of the health insurance market depends on various distribution channels available to insurers. Private companies have more distribution channels, while public sector providers often rely on agents, which can present certain challenges. There is no separate regulation governing the services of agents in the public sector.

Health insurance policies typically have a duration of one year and are renewable. However, they often include certain exclusion clauses. These terms and conditions, usually found in fine print, may require extra effort to read and understand. Some of the major exclusions in health insurance policies are:

Pre-existing diseases: All health insurance companies uniformly exclude coverage for pre-existing conditions.

Initial waiting period: During the first 30 days of coverage, claims for sickness or disease are not applicable (except for accidental injury claims).

Specific conditions during the first year: Certain conditions, such as cataract, hernia, congenital internal diseases, and sinusitis, may be excluded from coverage during the first year of the policy.

Exclusions for spectacles, contact lenses, hearing aids, dental treatments/surgeries not requiring hospitalization, pregnancy or childbirth-related treatments (including cesarean section), and naturopathy treatment.

The actual exclusions may vary depending on the insurance product and company. In group policies, it may be possible to waive or delete exclusions by paying an additional premium. Health insurance policies are typically issued foa minimum duration of one year[124].

Maternity expenses are dealt with separately, with a waiting period of one year. Under exceptional circumstances, the policy can be renewed within 7 days from the expiry date. The renewal of the policy is subject to mutual consent, and the insurance company is not obligated to provide a renewal notice. Unlike life insurance policies, health insurance policies clearly state that a "break in policy" occurs if the premium for renewal is not paid by the due date or within 30 days thereafter[125].

The Insurance Regulatory and Development Authority (IRDA) has imposed conditions for the withdrawal of health insurance products. Insurers must seek prior approval from the authority and provide reasons for withdrawal, along with complete details to existing policyholders. The policy document must indicate the possibility of future product withdrawals and the available options for policyholders in such cases. If existing customers do not respond to the insurer's intimation, the policy will be withdrawn upon renewal, and the insured individual will need to take a new policy, subject to portability conditions. The withdrawn product cannot be offered to prospective customers.

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[124]IRDA Hand book, Health Insurance, available athttp://www.policyholder.gov.in/uploads/CEDocuments/Health%20Insurance%20Handbook.pdf, (Last visited on June19, 2014)

[125]Reg.2(d)IRDA(HealthInsurance)Regulations2013.

Insurers may offer coverage for non-allopathic treatments if the treatment has been undergone in a government hospital or a recognized institute accredited by the Quality Council of India, National Accreditation Board on Health, or other suitable institutions. This provision allows insurance companies to expand their market share by providing coverage for indigenous treatments, benefiting both consumers and insurers.

Deferred coverage of Risk.

In health insurance contracts, certain risks are often not covered for a specific period, and there is typically a waiting period of 30 days before coverage begins. Unlike life insurance contracts where the risk is postponed and no consideration is received by the insurer, in health insurance contracts, consideration is received, and coverage is deferred. Both parties are aware of these conditions, and it is not considered unethical to have such clauses in insurance contracts. Signs and symptoms may be considered as pre-existing illnesses, which can be traced back up to four years but are often camouflaged as 48 months for reasons known to the insurer. In contrast, Section 45 of the Insurance Act only allows invocation of the warranty clause within two years. The four-year period in health insurance is considered too long and should be reduced. It is also important to consider whether certain risks can be covered without any waiting period.

Role of Third Party Administrator in Health Insurance

Regarding the role of Third Party Administrators (TPAs) in health insurance, there are three parties involved: the insured individual, the insurer, and the service provider (typically a hospital). The services provided by hospitals and doctors are critical and any delay in accessing resources could result in the loss of life in some cases. To manage cash flow efficiently in short notice, TPAs were introduced to handle health services. The Insurance Regulatory and Development Authority (IRDA) has issued regulations to monitor their activities[126]. TPAs are licensed entities engaged by insurance companies to provide health services for a fee. They process medical reimbursement bills, communicate claim rejections with reasons, and facilitate cashless settlements between hospitals and insurance companies. TPAs are not allowed to engage in any other business, and they are expected to adhere to a high level of moral and ethical discipline as outlined in the code of conduct.

[126]IRDA(ThirdPartyAdministrators-HealthServices)Regulations,2001

In terms of regulatory oversight in health insurance, the IRDA has issued regulations in 2013, which have been beneficial to policyholders. Health insurance products can only be offered by entities with valid registration under the IRDA regulations. Life insurance companies can offer long-term health products, but the premium must remain unchanged for a minimum of three years before it can be reviewed and modified. Non-life and standalone health insurers can offer individual health products with a minimum tenure of one year and a maximum tenure of three years, with the premium remaining unchanged during the tenure. Group health insurance policies are one-year renewable contracts, while group personal accident products can have a term of less than one year. Travel insurance policies, whether domestic or overseas, can only be offered by non-life and standalone health insurance companies, subject to approval by the IRDA.

Regulatory Role in Health Insurance.

Health policies are ordinarily renewable unless there are grounds for denial, such as fraud, moral hazard, misrepresentation, or non-cooperation by the insured. If the insurer denies renewal, the reasons must be communicated to the policyholder. The regulation allows for a 30-day grace period for renewal without deeming it a break in policy, but coverage may not be available during that period. However, it is not clear what happens if a claim occurs during the treatment period while the policy is renewed but was lapsed on the date of occurrence.

The regulator has mechanisms in place to monitor the implementation of the regulations, as health insurance is an evolving field that may require improvements and constant review. With advancements in medical science and treatment procedures, the terms and conditions of health insurance should be reviewed to incorporate these developments and extend benefits to consumers.

Standardization of conditions and exclusions is a significant step towards achieving consistency in health insurance policies. The Insurance Regulatory and Development Authority (IRDA) has defined specific terms and regulations to ensure standardization. Here are some key points:

a) Health insurance products can only be offered by entities that are registered under the Insurance Regulatory and Development Authority (Registration of Indian Insurance Companies) Regulations 2001.

b) Life insurance companies have the option to offer long-term health products. However, the premium for such products must remain unchanged for a block of three years. After that, the premium may be reviewed and adjusted as necessary.

c) Non-life and standalone health insurance companies can provide individual health products with a minimum tenure of one year and a maximum tenure of three years. During this tenure, the premium should remain unchanged.

d) Group health insurance policies can be offered by any insurance company, but they must be one-year renewable contracts. However, non-life and standalone health insurers can offer group personal accident products with a term of less than one year to cover specific events.

e) Overseas or domestic travel insurance policies can only be offered by non-life and standalone health insurance companies. These policies can be standalone products or add-on covers to existing health policies. The premium for the add-on cover must be approved by the IRDA under the File & Use procedure.

These regulations aim to bring consistency and clarity to health insurance offerings and ensure that policyholders are protected by standardized terms and conditions.[127]

[127]Reg.3,IRDA(TPA-HealthServices)Regulation,2001.

CHAPTER-V

CONCLUSION AND SUGGESTION.

CONCLUSION

Non-compliance with awards issued by the insurance ombudsman by insurance companies can lead to fear and a loss of trust among the public, ultimately defeating the main objective of the scheme. The effectiveness of the insurance ombudsman in resolving consumer grievances has been demonstrated, surpassing the civil court system in terms of efficiency. Unlike other countries, we have a dedicated ombudsman to address insurance-related complaints. In the fiscal year 2019-20, the insurance ombudsman received 38,538 complaints, out of which 29,816 were resolved, leaving only 8,722 outstanding cases.

This data highlights the effectiveness of the insurance ombudsman in resolving consumer grievances. However, the main issue with the insurance ombudsman lies in the implementation of its awards. Once an award is issued against an insurance company by the ombudsman, it is legally binding and must be implemented within 30 days, or 60 days if appealed. Unfortunately, some insurance companies refuse to comply with these awards.

The lack of power for the ombudsman to take action against non-compliant insurance companies undermines the purpose of the ombudsman scheme and erodes public trust in the system. In such cases, it would be more appropriate for affected individuals to approach consumer or civil courts. If the Insurance Regulatory and Development Authority of India (IRDAI) truly aims to assist citizens, action must be taken against insurance companies that fail to comply with the ombudsman's awards.

The initial hypotheses stated at the beginning of this discussion have been examined throughout the research, and the results are presented in Chapter IX. The efforts made by insurance companies and the government have successfully raised awareness about insurance at the grassroots level. However, it is evident that the terms and conditions of life and health insurance policies are complex, and consumers struggle to understand them, particularly regarding aspects such as nomination and assignment. Additionally, consumers are often reluctant to disclose all relevant information, and intermediaries fail to explain the

importance of providing such information. Consumer redressal agencies have not delivered the expected results, and there is a lack of clarity and significant delays in dispute settlement procedures at the district level.

Despite the Consumer Protection Act of 1986 being enacted 28 years ago, there are still fundamental issues that need to be addressed, including delays in appointing presidents and members and inadequate infrastructure at the district and state levels. The number of vacancies and delays in member appointments at the state and district levels are unsatisfactory. As this falls under the jurisdiction of state governments, it is crucial for them to establish a system for promptly filling these vacancies to minimize delays. Additionally, in the interest of consumers residing in southern parts of India, the National Consumer Disputes Redressal Commission (NCDRC) should consider establishing a permanent bench in one of the southern states, as currently, they only have circuit benches in selected areas.

There is a need for increased involvement and participation of Voluntary Consumer Organizations in educating and raising awareness about the benefits of the Consumer Protection Act, specifically highlighting the advantages of District Forums.

The proposed amendment to the Consumer Protection Act should include provisions granting the State Commission the power to review its own orders. This review power should also be extended to District Forums.

Considering the nature of disputes related to Life Insurance and Health Insurance, there should be consideration given to establishing a separate tribunal exclusively dedicated to handling such cases.

The existing IRDA (Agents Licensing) Regulation 2002 is insufficient in regulating insurance agents. It lacks penal provisions and only refers to a code of conduct. It is necessary to enhance the regulation and oversight of insurance agents.

Based on the findings of the research work, the following recommendations are made:

1. Voluntary Consumer Organizations should play a more active role in educating and creating awareness about the Consumer Protection Act, particularly highlighting the benefits of District Forums.

2. The proposed amendment to the Consumer Protection Act should empower both the State Commission and District Forums to review their own orders.

3. Consideration should be given to establishing a separate tribunal exclusively for resolving disputes related to Life Insurance and Health Insurance.

4. The regulatory framework governing insurance agents, specifically the IRDA (Agents Licensing) Regulation 2002, should be strengthened with the inclusion of penal provisions and stricter oversight.

Overall, implementing these recommendations will help improve consumer protection and ensure a more efficient and effective resolution of consumer grievances.

SUGGESTION

1. Formulate standard terms and conditions applicable to all life insurance companies and promote widespread awareness of these terms. Individual companies can have special clauses without affecting the basic terms and conditions.
2. Reconsider the definition of the term 'warranty' and avoid employing hyper-technical interpretations, particularly in consumer insurance. Warranty clauses should be invoked only in cases of fraud and not for other reasons.
3. Rethink the concept of "Uberrmiafieds" and provide a new definition for 'suppression.'
4. Amend "The Commercial Documents Evidence Act 1939" to include medical and hospital records in Part-I of the schedule.
5. Enact a law similar to the "Consumer Insurance (Disclosure and Representation) Act 2012" implemented by the British parliament in India.
6. Accelerate efforts by the Insurance Regulatory and Development Authority (IRDA) to include insurance in the school curriculum.
7. Recognize insurance agency as a profession and establish an independent autonomous self-governing professional body for governance, similar to the Indian Medical Association and Chartered Accountants Association of India.
8. Strengthen the role of the insurance regulator in creating consumer awareness about common terms and conditions of insurance policies by formulating or amending existing regulations. Guidelines should address common policy terms such as suicide clauses, grace periods, accident benefit requirements, unnatural

death, and accident definitions.

9. Amend the existing IRDA (Licensing of Insurance Agents) Regulation 2000 to include provisions for controlling agents in case of misconduct and fraud. Uniform regulations should be applicable to all insurance agents, regardless of whether they belong to public sector corporations or private companies.
10. Mandate that in cases of repudiation of life insurance policies with a sum assured of less than fifty thousand rupees, the matter must first be referred to the Insurance Ombudsman by the District Consumer Forum before admitting the complaint.
11. Reconsider the legal structure of the Ombudsman, adopting a pattern similar to that followed in the United Kingdom.
12. Exclude contractual matters involving fraud or deception from the jurisdiction of LokAdalat, as they are not suitable for resolution through alternative dispute resolution methods.
13. Mandate that disputes over rival claims and Life Insurance benefits be referred to LokAdalat, with suitable amendments made to the governing law.
14. Reevaluate the concept of waiting periods in health insurance policies. Inform consumers of all inclusions, exclusions, and the quantum of claim payable before the conclusion of the contract.
15. Establish a separate statutory authority to oversee all aspects of health-related issues, including health insurance and medical negligence, due to the multiple interpretations of exclusion clauses and the inadequacy of the current system of regulating medical professionals.

BIBLIOGRAPHY

- Anson. Law of Contract. Oxford University Press, 29th edition.
- Basu, Durga Das. Commentary on the Constitution of India. LexisNexis ButterworthsWadhwa Nagpur, Vol. 3, 8th edition, 2008.
- Birds, John, and Norma J. Hird. Birds Modern Insurance Law, 6th edition.
- Cheshire, Fifoot&Furmston's. Law of Contract. Oxford University Press, 15th edition.
- Chitty on Contracts, 24th Edition.
- Colinvaux's. Law of Insurance. London: Sweet & Maxwell, 8th edition, 1990.
- Halsbury. Laws of England, 4th edition.
- Huebner, S.S., Kenneth Black Jr. Life Insurance. Prentice-Hall, Inc., 10th edition.
- Indian Legal Institute. A Treatise on Consumer Protection Law. New Delhi, 2004.
- Insurance Law for the Construction Industry. Edited by Robert Hogarth. Oxford University Press.
- Ivamy, E.R. Hardy. General Principles of Insurance Law, 4th edition.
- Jain, M.P. The Code of Civil Procedure 1908. LexisNexis ButterworthsWadhwa Nagpur, 3rd edition, 2011.
- Lowry, John, and Philip Rawlings. Insurance Law: Doctrines and Principles. Oxford and Portland, Oregon, 2005.
- MacGillivray on Insurance Law. London: Sweet & Maxwell, 10th edition, 2003
- McGee, Andrew. Law and Practice of Life Assurance Contracts. Sweet & Maxwell, 1995.
- Oxford University Press. Clarendon Law Series, reprinted 2009.
- Ramsay, Iain. Rationales for Consumer Law and Policy. Consumer Law & Policy, 2nd edition.
- Saraf, D.N. Law of Consumer Protection in India. N.M. TripathiPvt. Ltd.

- Scott, Colin, and Julia Black. Granston's Consumer and the Law. Cambridge University Press, 3rd edition.
- Singh, BrijNandan. Insurance Law. The University Book Agency, Allahabad, 3rd edition.
- Singh, Gurjeet. The Law of Consumer Protection in India: Justice within Reach. Deep & Deep Publications.
- The Indian Law Institute. Annual Survey of Indian Law, Vol. XLIV, D.S. Sengar, 2008.
- The Lawyer's Co-operative Publishers Co. American Jurisprudence. Rochester, 2nd edition, 1982.
- Varma, S.K., et al. A Treatise on Consumer Protection Law. Indian Law Institute, 2004.
- Wollner, Kenneth S. Ebook: How to Draft and Interpret Insurance Policy.

Indian Legislations:

- Consumer Protection Act, 1987.
- Financial Services and Markets Act, 2000.

Foreign Legislations:

- Law of Property Act, 1925.
- Marine Insurance Act, 1906.
- Policies of Life Assurance Act, 1867.
- The Banking Regulation Act, 1949.
- The Code of Civil Procedure (Amendment) Act, 1956.
- The Commercial Documents Evidence Act, 1939.
- The Consumer Protection Act, 1986.
- The Drugs and Cosmetics Act, 1940.
- The Employee's Provident Funds and Miscellaneous Provisions Act, 1952.
- The Government Savings Banks Act, 1783.
- The Government Savings Certificate Act, 1959.
- The Indian Contract Act, 1872.
- The Indian Evidence Act, 1872.

- The Indian Penal Code, 1860.
- The Insurance Act, 1938.
- The Insurance Regulatory and Development Authority Act, 1999.
- The Legal Services Authorities (Amendment) Act, 2002.
- The Marine Insurance Act, 1963.
- The Married Women's Property Act, 1874.
- The Sale of Goods Act, 1930.
- The Transfer of Property Act, 1882.
- Unfair Contract Terms Act, 1977.

Reports/Bills/Codes/Regulations:

- 112th Law Commission Report on Section 45 of Insurance Act, 1938.
- 126th Law Commission Report.
- 129th Report of the Law Commission of India on Urban Litigation Mediation as an Alternative to Adjudication, 1988.
- 137th Report of the Law Commission of India on the need for creating the Office of Ombudsman and measures to relieve hardships in settling Provident Fund claims, 1989.
- 190th Law Commission Report on revision of Insurance Act and IRDA Act.
- 82nd Law Commission Report on Effect of nomination under Section 39 Insurance Act, 1938.
- 91st Law Commission Report on important sections of Insurance Act.
- Article by V. Ramakrishna on Plain English in insurance in the IRDA Journal, 2007.

Foreign Reports:

- Guidelines for Grievance Redressal by Insurance Companies.
- Insurance Contract Law Issues Paper 3.
- Redress of Public Grievances Rules, 1998.
- Report of the Working Group on Consumer Protection, Twelfth Plan (2012-17), Volume II Subgroup Report.
- Report on Financial Sector Legislative Reforms Commission (FSLRC).
- The Banking Ombudsman Scheme, 2002.
- The Life Insurance Corporation of India (Agents) Rules, 1972.

- The Unfair Terms in Consumer Contracts Regulations, 1994 (Scottish Law Commission).
- Various IRDA regulations on advertisements, disclosures, brokers, agents, policyholders' interests, web aggregators, health insurance, and third-party administrators.

APPENDICES

CERTIFICATE OF PLAGIARISM CHECK

Certificate Of Plagiarism Check
Title Of Work : CRITICAL ANALYSIS OF ROLE OF INSURANCE OMBUDSMAN IN INDIA
Author (S) Of Work :
Date Of Check:
Result Of Check:
Plagiarism Checking Tool Used
Statement Of Originality:
Name Of Person Conducting Check:
Signature:
Date: