



Demystifying Insurance Dispute Settlement in India: A Comprehensive Analysis

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ABSTRACT

With a focus on conflict types, legal frameworks, and settlement techniques, this paper offers a thorough overview of insurance dispute resolution in India. It highlights the significance of comprehending legal and regulatory frameworks by examining typical disagreements including claim denials and premium difficulties. Another dispute resolution process that provides policyholders with a quicker and more cost-effective option is examined: the Insurance Ombudsman Scheme. Along with internal grievance redressal procedures and judicial options, the role of the Insurance Regulatory and Development Authority of India (IRDAI) in promoting policyholder rights is examined. In addition, the article analyses important court rulings that shed light on how policies should be interpreted and what disclosure requirements should be met. In order to avoid conflicts and guarantee just claim settlements, it emphasises in its conclusion the significance of clear communication and legal knowledge.

KEYWORDS- Claim Settlement, Insurance Disputes, Ombudsman Scheme, IRDAI, Court Proceedings,

INTRODUCTION

As a safeguard against unanticipated events, insurance is, in fact, a vital component of contemporary living. Insurance is essential for reducing risks and ensuring financial stability, whether it is for protecting our investments, health, or property. Even with its importance, disputes and conflicts still arise in the insurance industry. As stated in the original form, there may be arguments between clients and insurance providers over a variety of issues, including coverage disputes, denials of claims, delays in settlement, and policy conditions. If these disagreements are not settled, they may strain the bonds between policyholders and insurers and jeopardise the basic goal of insurance, which is to offer prompt and sufficient protection. The resolution of disputes acquires crucial importance in the Indian setting, where the insurance sector is seeing fast growth and developing regulatory dynamics. Comprehending the complexities of insurance dispute resolution in India necessitates a sophisticated comprehension of the legal structure, regulatory protocols, and accessible channels of appeal.

TYPES OF INSURANCE DISPUTE IN INDIA

In India, there are many different circumstances that might lead to insurance disputes, including Claim denials, Delay in claim settlements, Premium disputes, Policy interpretation, and Non disclosure of information. These disagreements may arise from policies pertaining to life, health, automobile, or property insurance, among other insurance kinds. Every kind of disagreement calls for a different strategy and an awareness of the guiding legal and policy concepts.

These are some common sorts of insurance disputes that are broken down for you:

- 1. Claim Denials-** An insurance company's refusal to accept a policyholder's claim is one of the most common types of disputes involving insurance. Numerous factors, including policy limitations, non-compliance with policy conditions, or purported deception, may be the cause of these denials.
- 2. Delay in claim settlement-** Insurance claim processing and settlement delays are another common point of concern. Policyholders frequently have to wait a long time to get paid, which might cause them to become unhappy and possibly file a lawsuit.
- 3. Premium disputes-** Insurance disputes might also be brought on by disagreements about the payment of premiums. These disagreements could centre on things like inaccurate premium computations, contentious renewal conditions, or disagreements about the rates' application.
- 4. Policy interpretation-** Insurance plans have intricate wording and clauses that are open to interpretation. When consumers and providers cannot agree on how to interpret or apply a particular policy term, condition, or exclusion, disputes may result.

5. **Non disclosure of information-** An insurance policy may be void for failure to provide pertinent information through the enrollment procedure. Insurance companies may claim that policyholders concealed important information that would have affected the underwriting decision, which could give rise to disputes.

LEGAL FRAMEWORK AND LITIGATION PROCEDURE FOR INSURANCE DISPUTE IN INDIA

The Insurance Act 1938 and The Insurance Regulatory and Development Authority of India Act 1999 essentially provided the legislative foundation for insurance dispute resolution in India. These laws serve as the foundation for the creation of regulatory bodies, such as IRDAI known as Insurance Regulatory and Development Authority of India, which is essential for monitoring insurance activities and guaranteeing ethical behavior. In addition, rules pertaining to insurance disputes are included in both the Indian Contract Act of 1872 and the Consumer Protection Act of 1986.

A thorough legislative framework outlining the rights and duties of insurers and policyholders governs the handling of insurance disputes in India. The insurance dispute resolution litigation technique is a methodical approach designed to efficiently resolve disputes. The process normally starts when the party who feels wronged files a formal complaint with the relevant court or quasi-judicial venue. This party is typically the policyholder. The type of dispute and the terms of the insurance policy are two important considerations when selecting a venue. Following the filing of the complaint, the parties exchange pleadings, and then pre-trial proceedings are conducted with the goal of simplifying the issues and promoting settlement negotiations. Evidence is given, witnesses are questioned, and legal arguments are made in front of the adjudicating authority during trial processes. The authority resolves the insurance dispute by issuing a judgement or decision following a thorough analysis of the available facts and the relevant legal arguments. Parties who disagree with the ruling may file an appeal for a review in higher courts. Mechanisms like asset attachment or execution procedures may be used to enforce the final judgement or order. In order to navigate the complexities of insurance law and reach a just and equitable result for all parties concerned, attention to procedural standards and legal knowledge is essential throughout the litigation process. Parties may also look at other options like mediation or arbitration to speed up the process and save costs, even if litigation provides a legal forum for resolving disputes.

AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM: INSURANCE OMBUDSMAN

Even though it provides a final means of resolving conflicts, the traditional court system frequently poses difficulties for policyholders trying to resolve insurance claims. For many people, the legal system's drawn-out processes, expensive litigation, and complexity can be intimidating. Acknowledging these constraints, India provides the Insurance Ombudsman Scheme, an alternative dispute resolution (ADR) tool tailored for insurance issues. This programme, which was started in 1998, gives policyholders a quicker, easier, and more affordable way to settle their complaints with insurance providers.

The Ombudsman scheme works under the regulations of the IRDAI known as Insurance Regulatory and Development Authority of India. It operates via a nationwide network of Ombudsman offices, each of which has jurisdiction over a certain geographic area. A policyholder must file a complaint with their insurance company before they can use the programme. The policyholder may then register a complaint with the Ombudsman if the company's response is inadequate or if no answer arrives within the allotted period (usually one month).

There are requirements that must be met in order to be eligible to make a complaint with the Ombudsman. The disagreement must primarily concern a particular insurance policy that was issued by an Indian insurance company that is registered. Furthermore, the claim amount normally lies within a predetermined range, however the exact limit may change based on the kind of insurance (general or life). A time-bound benefit is also provided under the Ombudsman programme. It is necessary to file complaints within a year of the insurer rejecting the demand or from the last correspondence from the business.

The Ombudsman's complaint filing procedure is intended to be easily navigable and accessible. Complaints made online can be submitted via the IRDAI website, or offline complaints can be submitted by mailing the required form and any necessary supporting documentation. Afterwards, the Ombudsman office looks into the complaint by going over the policy documentation, correspondence involving the insured and the insurer, and any other relevant data. The Ombudsman may also request meetings with both parties during the investigation to hear their viewpoints.

The Ombudsman might make recommendations for other means of remedy, such as offering particular services or correcting policy documentation, or he can issue awards in the policyholder's favour and order the insurer to pay a certain sum. The Ombudsman's rulings carry a lot of weight and are generally followed by insurance providers, even if they are not enforceable by law. If the insurer does not comply, the Ombudsman may refer the issue to IRDAI, which has the authority to penalise the insurer.

ROLE OF IRDAI (INSURANCE REGULATION AND DEVELOPMENT AUTHORITY OF INDIA)

In charge of monitoring and advancing an impartial and effective process for resolving insurance disputes in India is the Insurance Regulatory and Development Authority of India (IRDAI). The (IRDA) was founded in 1999 and uses a variety of strategies to safeguard policyholders and expedite claim payouts. Establishing and overseeing the Insurance Ombudsman Scheme is one of IRDAI's main responsibilities. This important alternative dispute resolution (ADR) process gives consumers a quicker and easier way to voice complaints to insurance providers. IRDAI establishes the requirements for qualifying to file complaints with the Ombudsman, as well as the deadlines for submitting disputes and the thresholds for claim values. Additionally, it manages the establishment and operation of Ombudsman offices across the nation, guaranteeing consumers' geographic accessibility.

In addition to the Ombudsman programme, IRDAI actively advocates for education and knowledge of conflict resolution techniques. It regularly distributes information via publications, awareness programmes, and its website about insured persons rights and available routes for redress. As a result, policyholders are better equipped to comprehend their choices and proceed through the dispute resolution procedure with confidence. In addition, IRDAI aggressively controls how insurance companies handle claims and settle disagreements. It establishes standards for equitable claim settlement procedures, guaranteeing that businesses follow open protocols and promptly address policyholder questions. When unfair practices are discovered, IRDAI looks into them and penalises the businesses that violate the law. This regulatory monitoring encourages a more responsible insurance industry by acting as a deterrent to unethical behaviour.

STEPS FOR THE PROCEDURE FOR RESOLVING INSURANCE DISPUTES:

1. Filing a Complaint with Insurance Company

- Gather all the paperwork you need, including your insurance policy, claim form, and any correspondence you have with the firm, before filing a complaint. Policies, complaint forms, reports from doctors (for health insurance), certificate of death (for life insurance), repair estimates (for property insurance), and letters of denial from the insurer are all included in this.
- Write a formal complaint that outlines the particulars of your disagreement. Indicate the policy number, the specifics of the claim, and the reasons you think the firm made a mistake in its judgement. Include any necessary supporting documentation with your claim. Many insurance firms provide online complaint portals; however, for a reliable record, it is best to send a hard copy together with supporting documentation via registered mail.
- Keep time constraints in mind. Insurance firms usually have time limits within which they must address grievances. If you don't hear back from them within the allotted time (typically 30 days), keep track of your attempts to get in touch with them and move on to the next round.

2. Internal Grievance Redressal Mechanism

- An internal grievance redressal process is mandated by law for the majority of insurance companies operating in India. Find the department or grievance officer assigned to your company, and take your issue further.
- Your grievance and any accompanying documentation will be examined by the grievance officer. If more details are required, they could ask for them. This is your chance to strengthen your argument and address any issues brought up by the business's original judgement.

3. The Insurance Ombudsman Scheme

- You can file a complaint with the Insurance Ombudsman if you are still unhappy with the resolution reached throughout the internal grievance redressal process. However, there are requirements for eligibility before choosing this choice. The claim amount normally comes under a pre-defined range, and the dispute must be unique to an insurance policy provided by an Indian insurance firm that is registered (see the IRDAI website for current restrictions).
- Online complaints can be sent to the Ombudsman via the IRDAI website, or offline complaints can be submitted by mailing the required form and any necessary supporting documentation. Make sure your complaint is filed within a year of the last correspondence you received or the date the insurance rejected the claim.
- The Ombudsman office looks into the complaint by going over correspondence logs, documents, and maybe holding hearings with both sides. The aim of mediation or conciliation is to arrive at a mutually agreeable resolution.

4. Legal Recourse

Legal action may be taken through the relevant civil court if the policyholder is dissatisfied with the insurance ombudsman's ruling or if the disagreement is outside of the ombudsman's purview.

JUDICIAL PRECEDENTS IN INSURANCE DISPUTS SETTLEMENT

1. Oriental Insurance Company Limited vs. M/s Narbheram Power and Steel Pvt. Ltd., (2018).

This Supreme Court ruling emphasises how policy exclusions should be interpreted as well as how the burden of proof is assigned in insurance disputes. The issue in this instance started when the insured, Narbheram Power and Steel Pvt. Ltd., filed a claim with Oriental Insurance Company Limited (the insurer) citing property damage from a storm. On the other hand, because of a few policy exclusions, the insurer rejected the claim.

The meaning of these limitations and the onus of demonstrating their applicability formed the core of the argument. The Supreme Court highlighted the need to interpret policy wording discrepancies in the insured's advantage. The insurer was responsible for providing a convincing justification for the exclusion. The court decided that it would not be adequate to simply reject the claim without offering particular justifications or a thorough justification for using an exclusion clause. This judgement establishes a significant threshold that insurers must meet in order to prove a direct connection between

the loss that is being claimed and the particular policy exclusion they are depending on. The Narbheram Power case highlights the value of open and honest communication in insurance disputes, especially when insurance companies try to reject claims on the grounds of exclusions.

2. **Dr. Shanthi Rengarajan vs The Oriental Insurance Company Ltd (2018):**

This case examines the legality of exclusions from coverage based on unclear language in the insurance contract, with a focus on already present medical issues. Dr. Rengarajan's family had health insurance, so she filed a claim when her son needed surgery for a genetic disease called familial adenomatous polyposis (FAP). Nevertheless, pointing to a policy exemption for pre-existing conditions, Oriental Insurance Company Ltd. (OICL) rejected the claim.

The main point of contention was how the exclusion clause should be interpreted and how clear it should be in relation to FAP. The policy's wording, according to Dr. Rengarajan, was unclear and did not specifically list FAP as a pre-existing illness. In this instance, the court emphasised the idea that policy language should be interpreted to the policyholder's advantage when there is ambiguity. The exclusion provision did not contain precise language about FAP, hence the court decided in favour of Dr. Rengarajan. Insurance companies should take note of this case as it highlights the importance of using clear and specific wording when determining exclusions, particularly with regard to pre-existing medical problems. It emphasises how crucial open communication and openness are in insurance contracts to prevent disagreements and guarantee that policyholders are aware of the extent of the coverage they are acquiring.

3. **The New India Insurance Co. Ltd. vs. Ms. Manjula (2013):**

This case highlights how crucial it is for the policyholder to fairly disclose all relevant information during the application procedure. It is the policyholder's duty to provide all pertinent information throughout the application process, and the insurer's duty to make clear what kinds of information are important for a certain policy. This case acts as an indication that beneficiaries attempting to make claims on a life insurance policy may face serious repercussions if there is a disclosure breach.

4. **National Insurance Co. Ltd. vs. Queen Mary's School (1992):**

In this particular case, the policyholder, Queen Mary's School, most certainly had a property damage insurance coverage. Presumably, there was an event that led to property damage at the school. After the school made a claim with National Insurance, the insurer paid the school for the losses it had suffered. But the tale doesn't stop there.

By employing the subrogation concept, National Insurance most likely located a third party who may lawfully be held accountable for the property damage to the school. This can have been an incompetent person, a contractor working on a building project, or another organisation. Subrogation effectively gave National Insurance the ability to sue this third party on behalf of Queen Mary's School to recoup the funds they had to pay out in the claim settlement.

CONCLUSION

The settlement of insurance disputes in India requires a sophisticated comprehension of the legal and regulatory frameworks, as well as the many options for settlement. Typical conflict categories that highlight the intricacy of insurance-related conflicts are denials of claims, premium disputes, delays in settlements, policy interpretation problems, and non-disclosure of information. In addition to alternative dispute resolution procedures like the Insurance Ombudsman Scheme, which is supervised by the Insurance Regulatory and Development Authority of India (IRDAI), policyholders have access to legal remedy through the judicial system that allows them to seek redress quickly and effectively. Notable court decisions emphasise that in order to reduce conflicts and guarantee equitable dispute settlements, it is critical to maintain open lines of communication, interpret policy language fairly, and implement transparent disclosure policies. In the end, building confidence and protecting the interests of insurers and policyholders equally depend greatly on developing open lines of communication, raising legal literacy among stakeholders, and upholding moral principles in the insurance sector.

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