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RE-EVALUATING THE PRINCIPLE OF UTMOST GOOD FAITH IN INDIAN INSURANCE LAW: A CASE FOR LEGISLATIVE REFORM

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I. ABSTRACT

Indian insurance law is based on the legal principle of uberrimae fidei, which means “utmost good faith.” This principle was created to fix the problem of information asymmetry between the insurer and the insured. In today’s market, though, powerful insurance companies are using this doctrine more and more to deny claims based on technical non-disclosures. This creates a big power imbalance that goes against the main social goal of insurance, which is to be a safety net, and it leaves policyholders who are already vulnerable unfairly exposed. This raises important questions about consumer protection and fairness in contracts. This article critically analyses the Insurance Act of 1938, its related regulations, and the development of Supreme Court case law through a doctrinal legal framework enhanced by socio-legal and constitutional viewpoints, to assess the doctrine’s practical implications. The analysis indicates a discernible judicial trend aimed at alleviating the severity of uberrimae fidei, as the Supreme Court increasingly incorporates principles of proportionality and fairness. Even with these improvements, policyholders are still not well protected because the rules are too broad, and the enforcement is too weak. The results show that just changing the way the courts work is not enough. This article advocates for a thorough legislative reform, suggesting particular modifications to the Insurance Act of 1938 to substitute uberrimae fidei with a legal ‘duty of fair presentation’ and to establish a framework for proportional remedies. These kinds of changes would make fairness and justice a part of the system, making sure that the law helps people instead of making their lives harder.

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II. KEYWORDS:

Insurance Law, Utmost Good Faith (*Uberrimae Fidei*), Section 45, Proportionality Test, Material Non-Disclosure, Unfair Contract Terms, Insurance Regulatory and Development Authority of India (IRDAI) Regulations, Consumer Protection, and Repudiation of Claims

III. INTRODUCTION

Insurance contracts in India have a unique and sometimes conflicting role. It appears to be a commercial contract subject to the Indian Contract Act, 1872. Its social and economic purpose goes beyond business; it provides social security, risk distribution, and financial stability in the face of life's worst uncertainties. The commitment is based on centuries-old English common law principles. These rules aim to balance the power of the powerful insurer and the vulnerable insured. *Uberrimae fidei*, or the duty of absolute good faith, is the most important principle and the foundation of insurance law. This rule requires insurance contract parties to disclose all relevant information in a complete and truthful manner.

This principle makes sense because it helps the insurer accurately assess risk. This article claims that insurance companies have oppressed people in the real world using the doctrine of uttermost good faith. Modern Indian insurance markets are characterised by power, information, and legal knowledge imbalances. Classic contracts of adhesion, insurance policies are composed by numerous corporate lawyers and are provided to the consumer on a "take-it-or-leave-it" basis.³ The insured is compelled to accept the terms of adhesion, as the Supreme Court has stated in the case of *LIC of India v Consumer Education and Research Centre*.⁴ The average person, who may not possess a high level of expertise in law or finance, cannot be expected to comprehend the intricacies of these documents or comprehend what a remote insurance underwriter deems to be a "material" fact.

³ See *General Assurance Society Ltd v Chandumull Jain* [1966] 3 SCR 500.

⁴ *LIC of India v Consumer Education and Research Centre* (1995) 5 SCC 482, [47].

According to the strict and traditional interpretation of the law, an insurer may decline a genuine, life-altering claim—such as the loss of a home, the death of a family’s primary breadwinner, or a major medical procedure—because the policyholder failed to disclose a minor, outdated illness or piece of information at policy purchase, which could have occurred years or even decades ago. It is evident that this is an injustice, a “*downtrodden concern*,” in which the very thing that was intended to protect people becomes a source of tremendous pain.

A. Scope of Research

The following research question is addressed in this paper: To what extent has the traditional, insurer-centric interpretation and application of the principle of *uberrimae fidei* in Indian insurance law resulted in a systemic power imbalance that undermines the social security objective of insurance and results in the unjust rejection of valid claims, necessitating the recalibration of the doctrine in court and in law?

B. Research Methodology

The central thesis of this paper is that insurers in contemporary India have employed the doctrine of uttermost good faith, which originates from a period in which information was not as readily accessible, as a weapon against consumers. Although the Supreme Court has made strides in incorporating equity and proportionality into this unjust covenant, a comprehensive and equitable resolution necessitates a significant legislative overhaul to safeguard the constitutional right to social security.

The principal research methodology is doctrinal, entailing a critical examination of statutes—primarily the Insurance Act, 1938; the IRDA Act, 1999; and the Indian Contract Act, 1872—and judicial precedents. The case law analysis examines significant Supreme Court of India rulings obtained from legal databases like SCC Online and Manupatra, spanning from 1999 (coinciding with the establishment of the IRDAI and the liberalization of the insurance sector) to the present day (2025). The main reason for choosing cases was that they had precedential value in interpreting *uberrimae fidei* and changing the way the courts look at policyholder rights.

This doctrinal core is fortified by a socio-legal perspective that analyses the tangible effects of claim denials on individuals and families. A major part of this paper is also its comparative with the legal system in the UK. This paper will extensively reference the UK's Consumer Insurance (Disclosure and Representations) Act 2012, utilising it as a principal benchmark and a prototype for the legislative reforms suggested for India. This multifaceted approach is crucial because the issue exists at the convergence of legal doctrine, its societal implications, and the pursuit of effective, globally informed solutions.

C. Chapterization

Four sections comprise this article. First, it will deconstruct insurance law, focussing on the *uberrimae fidei* doctrine's historical justifications and current challenges. The second section will focus on the Supreme Court's shift from a contractual to a consumer-protective, constitutional approach. Thirdly, it will assess the Insurance Regulatory and Development Authority of India (IRDAI) as the sector's monitor for performance. In conclusion, it will propose a comprehensive and specific set of laws to modify the duty of disclosure, improving insurance fairness, transparency, and justice for all Indians.

IV. THE PRINCIPLES OF THE PAST: DECONSTRUCTING *UBERRIMAE FIDEI*

Under the law, an insurance contract is referred to as a contract *uberrimae fidei*. This sets it apart from conventional business contracts, which are predicated on the principle of caveat emptor (let the consumer beware). Under a standard contract, neither party is obligated to disclose information unless they choose to do so; each party is accountable for conducting their own due diligence. Under the law, both parties to an insurance contract are obligated to disclose the truth.

A. The Historical Rationale: *Carter v. Boehm* and Informational Asymmetry

Carter v. Boehm, a classic 18th-century English case, is the source of this superior duty.⁵ The case concerned an insurance policy on a fort in Sumatra that safeguarded it from

⁵ *Carter v Boehm* (1766) 3 Burr 1905, 1909.

being captured by a foreign enemy. Despite the fact that the superintendent of the fort, who obtained the policy, was aware of the fort's deficiencies and the likelihood of a French attack, he refrained from informing the insurance company in London. In his significant decision, Lord Mansfield laid out the fundamental concepts that underpin the doctrine. His belief was that insurance is a contract founded on speculation, and the contingent chance is typically only known to the insured due to the unique facts that comprise it. The underwriter is confident in his statements and proceeds under the assumption that he is not concealing any information that would prompt the underwriter to deny the existence of the situation. Lord Mansfield famously exclaimed, "*Good faith forbids either party from drawing the other into a bargain by hiding what he privately knows and making the other believe the opposite.*"⁶

At the time, the rationale was straightforward and logical: the proposer, who was believed to possess complete and exclusive knowledge of the risk being insured, was unable to verify this information, as the insurer, who was frequently situated thousands of miles away, had no means of doing so. To address this information gap, the law imposed a strict obligation on the proposer to proactively disclose all the facts that a "*prudent insurer*" would consider significant for risk assessment.

B. The Draconian Consequences of Breach

If you violate this obligation of the highest good faith, the consequences are severe. The insurer has the right to terminate the contract from the outset if the insured fails to disclose a fact that is subsequently determined to be "*material*" or if they fabricate information that is "*material*". This remedial action is known as rescinding the policy, which permits the insurer to operate as though it never existed. No longer are they required to pay the claim; they are only required to reimburse the policyholder for the premiums they paid. The insurer's right to terminate the contract is available regardless of whether the nondisclosure was entirely innocent or inadvertent. The fact that was not disclosed is still available, even if it is unrelated to the actual loss that occurred.

⁶ *ibid.*

Inequitable consequences are apparent. An applicant for life insurance may not disclose a decade-old minor surgery. In the event of a car accident years later, the insurance company can use this innocent omission to claim that the medical history was “*material*” and deny the death claim, leaving the family with nothing. If the doctrine is strictly enforced, the unreported surgery did not cause death. This defines the unjust conventional principle. It lets insurers legally conduct “*post-claim underwriting*,” which involves determining a reason to deny a claim after it has been lodged, even after collecting premiums for a long time.⁷ For example, in *Sulbha Prakash Motegaonkar v. Life Insurance Corporation of India*⁸, the Supreme Court of India strongly criticised this practice. The court said that an insurer cannot deny a claim because they could have found out about it during the initial underwriting process if they had been careful.

Informational asymmetry’s original cause has been reduced or eliminated. Information is no longer enough for insurers. These massive, data-driven companies have extensive underwriting procedures, databases, the authority to require comprehensive medical exams, and the funds to conduct thorough investigations before issuing their policies. Customers have less power and information. The sword of *uberrimae fidei*, developed in a different era and location for business and technology, is still used by insurers to deny claims and protect their financial interests.⁹

V. CHAPTER III. THE JUDICIAL SHIELD: THE SUPREME COURT’S SHIFT TOWARDS A PRO-POLICYHOLDER STANCE

Over the past two decades, the Supreme Court of India has developed a greater understanding of the unjust nature of applying the uttermost good faith doctrine in a strict, insurer-centric manner. The Court has rendered a series of groundbreaking decisions that have deliberately mitigated the severity of the common law principle

⁷ See discussion in *Manmohan Nanda v United India Insurance Co Ltd* [2021] SCC OnLine SC 1210 [26].

⁸ *Sulbha Prakash Motegaonkar v Life Insurance Corporation of India* [2015] SCC OnLine SC 1852.

⁹ John Birds and others, *MacGillivray on Insurance Law* (12th edn, Sweet & Maxwell 2012) para 17-086.

by incorporating reasonableness, proportionality, and fairness. In effect, this has transformed the insurance contract from a solely business agreement to one that serves a constitutional and social purpose.

A. Establishing the Burden of Proof and the Reciprocal Nature of the Duty

One of the first and most important things that needed to be done to fix the courts was to make clear what the right place and standards were for challenging an insurance company's actions. The Supreme Court in *Life Insurance Corporation of India v Asha Goel*¹⁰ did talk about how important it is for insurers to have clear evidence when they deny claims, but its main contribution was to set the standard for when a writ petition under Article 226 of the Constitution can be filed against the State insurer (LIC). The Court ruled that the High Court could use its writ jurisdiction to deal with contract disputes involving a state entity, but it usually wouldn't deal with disputes that involved complicated factual issues, like whether a non-disclosure was fraudulent. This decision was very important because it sent most insurance disputes to consumer forums and civil courts. It also made it clear that repudiation is a serious problem that needs strong proof.

The law in the case of *Sulbha Prakash Motegaonkar v. Life Insurance Corporation of India*¹¹ underwent a more pronounced pro-policyholder shift. In this instance, the insurer declined a death claim due to the fact that the individual who passed away had not disclosed a minor ailment on the proposal form, despite the fact that the insurer's physician had examined the individual. The Supreme Court issued a resounding ruling that the "*duty of utmost good faith*" is a reciprocal obligation that binds both the insurer and the insured. It stated that insurers are unable to request that the insured "*scrupulously comply with the terms of the proposal form*" while they are themselves engaged in a "*casual*" underwriting process.¹² The Court emphasised that the objective of an insurance policy is to ensure social security and that it cannot be used as a "*source of profit*" for the insurer through "*specious pleas*." The decisive *ratio* of this ruling is that an insurer who has had the opportunity to verify the facts (e.g., by obtaining a medical

¹⁰ *Life Insurance Corporation of India v Asha Goel* (2001) 2 SCC 160.

¹¹ *Sulbha Prakash Motegaonkar* (n 6).

¹² *Sulbha Prakash Motegaonkar* (n 6) at para 18.

exam or requesting additional records) is prohibited from denying a claim in the future due to a minor nondisclosure that could have been easily identified. The principle of reciprocity isn't just an Indian object; English courts have also said that the insurer has a duty of good faith to the insured, like when they handle claims.¹³

B. The Shift from Materiality to Fraudulent Intent and the Nexus Test

The most significant development in this area, primarily due to Justice D.Y. Chandrachud's judgements, is that the focus has switched from punishing non-disclosers to assessing the policyholder's intent and how the facts pertain to the claim. *Manmohan Nanda v United India Insurance Co. Ltd.* is a case of significant importance. It is a distinct example of this approach, as it was determined in 2021.¹⁴ The case was about an overseas travel insurance policy that covered a trip to the US. The policyholder had other insurance policies before and had made a claim on one of them, but he didn't tell the travel policy company about this when he applied. His claim for medical bills he had to pay in the US was denied because he didn't tell the truth about this "material" fact. The Court, led by Justice D.Y. Chandrachud, asserted that the rejection of a policy must be "just and fair."¹⁵ The Court determined that the insurer could only avoid the contract if the non-disclosure was "fraudulent." It required a "deliberate and intentional" concealment of a fact that the policyholder knows to be "material" is required. The policyholder must act in bad faith, with intent, or fraud before the extreme measure of repudiation can be justified, which effectively shifts India's position away from the strict English common law rule (where even an innocent non-disclosure can void the policy).

Also in the case of *Life Insurance Corporation of India v. Sunita*, the Supreme Court established a critical "nexus test" for health insurance claims.¹⁶ The Court held that an insurer cannot reject a claim because a person didn't tell them about a pre-existing condition unless that condition is both important and directly linked (a nexus) to the cause of death or the specific illness for which the claim is made. This means that an

¹³ *Banque Financière de la Cité SA v Westgate Insurance Co Ltd* [1991] 2 AC 249

¹⁴ *Nanda* (n 5).

¹⁵ *Nanda* (n 5) [43].

¹⁶ *Life Insurance Corporation of India v Sunita* [2021] SCC OnLine SC 183.

insurance company can't deny a claim for a heart attack because the policyholder failed to inform them about an unrelated orthopaedic surgery they had in the past. The undisclosed fact must be the direct cause of the event that starts the claim.¹⁷ This is a groundbreaking initiative that directly combats the injustice of the insurance company denying a heart attack claim due to the individual's failure to disclose a minor orthopaedic surgery that occurred in the past. These decisions demonstrate the courts' constitutional role in balancing the contractual rights of the insurer with the fundamental social and economic rights of the citizen to safety and dignity when read collectively.

VI. CHAPTER IV: THE WATCHDOG'S ROLE: AN EVALUATION OF THE IRDAI'S INTERVENTIONS

In 1999, the Insurance Regulatory and Development Authority of India (IRDAI) was established under the IRDA Act with the primary objective of "*protecting the interests of the policyholders.*"¹⁸ The IRDAI has implemented a variety of regulatory measures to prevent the practice of unjust claim rejection. These regulations encompass a significant number of the regulations that regulate the insurer's relationship with the policyholder. Regulation 3 mandates that insurers must have a policy that has been approved by the board in order to safeguard the interests of policyholders. According to Regulation 4, the insurer is required to provide the prospect with all the necessary information regarding the policy. Regulation 9 is crucial because it establishes the insurer's liability for any errors that may occur when an agent completes the proposal form. Additionally, Regulation 13 establishes stringent deadlines for resolving claims, while Regulation 14 mandates that any denial of a claim must be in writing and explicitly specify the reason for the denial.

The Regulations for the Protection of Policyholders' Interests, 2017, are the most significant of these. Many of the regulations that regulate the insurer-policyholder relationship are enumerated in these regulations. According to Regulation 4, the insurer is required to provide the prospect with all pertinent information regarding

¹⁷ *Maniben Mehulbhai Shah v Life Insurance Corporation of India* [2021] SCC OnLine SC 322 [16].

¹⁸ Insurance Regulatory and Development Authority Act 1999.

the policy.¹⁹ Regulation nine is of paramount importance due to its discussion of the proposal form.²⁰ It was stated that the insurer is accountable for any errors that may be made if the proposal form is completed by the insurer's agent, which is essentially the principle of agency.

The single most critical component of the regulatory framework that safeguards individuals is the "*incontestability clause*," which was initially incorporated into Section 45 of the Insurance Act, 1938. This section was significantly strengthened by the Insurance Laws (Amendment) Act of 2015, which extended the period of time during which a claim could not be contested from two years to three years.²¹ This three-year lock-in period is of paramount importance for safety. It renders the contract irrevocable and prevents the insurer from utilising purported non-disclosures that are outdated to deny a claim after a significant period of time has elapsed, during which the policyholder has submitted premium payments punctually. The three-year period is used to ensure that insurance companies complete their underwriting and investigations.

However, the regulations and the norms do have significant issues.

- **Limited Scope of Incontestability:** Despite its significant protection, the three-year incontestability clause is only applicable to life insurance policies. It does not cover health, Mediclaim, or other general insurance. This huge inequality is unjust. Health insurance industry tensions stem from unfair pre-existing condition denials. A citizen's request for life-saving surgery may be denied if they lie about a minor illness. The incontestability clause prevents this.
- **Weak Enforcement and Grievance Redressal:** While the regulatory framework is established, it is not functioning effectively due to challenges with enforcement and resolving issues. For example, the IRDAI implements measures; however, the penalties are frequently inadequate to mitigate the

¹⁹ Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations 2017, reg 4.

²⁰ Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests) Regulations 2017, reg 9.

²¹ Insurance Act 1938, s 45.

issue. In 2023, the IRDAI imposed a fine of ₹1 Crore on a major private insurer for violating the claim settlement guidelines, specifically citing the delays and the improper denial of health insurance claims.²² However, a significant number of individuals believe that these measures are insufficient to address an industry-wide issue. An additional avenue for assistance is the Consumer Grievance Redressal System, which encompasses the Insurance Ombudsman; however, it is not without its own limitations. As per the 2022-23 Annual Report of the IRDAI, the 17 Ombudsman offices in India addressed 50,161 complaints out of 55,946 that year.²³ Although numerous individuals receive awards from the Ombudsman, policyholders frequently must undergo a protracted and costly process in civil courts or consumer forums in order to receive payouts. This is due to the fact that the awards are not always legally binding, as opposed to a court decree, which decreases the mechanism's "teeth."

VII. CHAPTER V: SUGGESTIONS & RECOMMENDATIONS: ENHANCING THE FAIRNESS OF THE INSURANCE COVENANT

A number of significant modifications are required to ensure that the insurance system is genuinely equitable and just, and to grant the Supreme Court's progressive legal decisions the legal weight of law. One of the objectives should be to transform the "asymmetrical covenant" into an equitable partnership.

A. Legislative Reforms to the Insurance Act, 1938

1. Replacing 'Utmost Good Faith' with a Statutory 'Duty of Fair Presentation':

²² See IRDAI, 'Final Order in the matter of M/s Go Digit General Insurance Limited', Ref No: IRDAI/ENF/ORD/ONS/251/10/2023, (October 4, 2023), available at <https://irdai.gov.in/document-detail?documentId=4544749> accessed 11 August 2025.

²³ Insurance Regulatory and Development Authority of India, *Annual Report 2022-23*, Chapter 12, p 145, available at <https://irdai.gov.in/document-detail?documentId=4693941> accessed 11 August 2025.

- **The Loophole:** Common law principle of *uberrimae fidei*, which is outdated, unclear, and centred around insurers.
- **The Solution:** In order to replace the common law principle with a legal “Duty of Fair Presentation” for all consumer insurance contracts, including life, health, and general insurance, Parliament should amend the Insurance Act. The definition of this new obligation would be more explicit. Rather than a vague obligation to disclose every fact that a “prudent insurer” may deem significant, the consumer’s obligation would be to be cautious not to lie and to provide the insurer with honest and comprehensive responses to the specific questions posed in the proposal form, to the best of their knowledge and belief.
- **Justification:** This modification, which is established by the United Kingdom’s Consumer Insurance (Disclosure and Representations) Act 2012 (specifically Section 2, which establishes the ‘duty to take reasonable care not to make a misrepresentation’, and Schedule 1, which outlines the proportional remedies), appropriately assigns the insurer’s obligation to enquire.²⁴ Rather than imposing an impossible burden of speculative, unsolicited disclosure on the average individual, it is the professional responsibility of an insurance company to ask clear and specific questions if they require specific information.

2. Introducing a Statutory Framework of Proportional Remedies:

- **The Loophole:** the current “*all-or-nothing*” remedy, allows insurers to terminate an entire policy for a minor, unrelated nondisclosure. This is known as the “*loophole*.”
- **The Solution:** The amended Act must establish a legal framework that provides **proportional remedies** for not disclosing or misrepresenting information prior to the execution of a contract. The insurer must administer a penalty that is commensurate with the policyholder’s

²⁴ Consumer Insurance (Disclosure and Representations) Act 2012.

actions and the insurer's response if it had been informed of the full narrative.

(i) Innocent and Non-Reckless Misrepresentation: The insurer is not permitted to terminate the policy if the misrepresentation was non-intentional or negligent. In the event that the insurer had continued to issue the policy with alternative terms, such as a higher premium, they would be obligated to pay the claim. However, they may reduce the claim amount by the premium rate differential.

(ii) Deliberate or Reckless Misrepresentation: The severe right to deny the claim entirely and avoid the policy ab initio and should repudiate the claim entirely only in cases where the non-disclosure was intended to deceive the insurer and was either intentional or negligent.

- **Proposed Legislative Text:** Amendment to the 1938 Insurance Act by including a new section, such as "Section 45A - Consumer's Duty of Disclosure"
 - (1) This section pertains to all forms of consumer insurance, including general, health, and life insurance.
 - (2) The common law rule of *uberrimae fidei* (utmost good faith), which mandates that the consumer disclose all pertinent information, is no longer in effect.
 - (3) In contrast, a consumer is required to provide a comprehensive and accurate response to all enquiries posed by the insurer to the best of their ability and knowledge.
 - (4) In the event that a consumer violates the duty outlined in sub-section (3), the insurer's remedy will be determined by the insurer's action if the consumer had fulfilled their obligation, as outlined in the framework of proportional remedies in the Schedule to this Act.
- **Justification:** This eliminates the inequity of the existing system. This ensures that the solution is appropriate for the issue. This measure would

prevent insurers from using minor, innocent errors by policyholders as a justification to avoid paying for genuine claims that have the potential to transform an individual's life, while simultaneously safeguarding them from fraud.

3. Expansion of the Three-Year 'Incontestability Clause' to Health Insurance:

- **The Loophole:** Currently, the incontestability clause in Section 45, which is the most critical protection, is only applicable to life insurance policies.
- **The Solution:** In order to elucidate that the three-year period of incontestability pertains to individual and family health insurance policies, it is necessary to amend Section 45 of the Insurance Act, 1938. This can be achieved by adding a new explanation to the section:

"Explanation III: For the removal of doubt, it is hereby clarified that the provisions of this section, including the three-year period of incontestability, shall apply *mutatis mutandis* to all individual and group health insurance policies."

- **Justification:** This is likely the most critical modification that must be implemented to safeguard consumers. It is imperative to have health insurance; it is not a luxury. After paying premiums for three years, individuals must be assured that their health insurance is secure and cannot be questioned at a later date due to information they were not informed of in the past, particularly when they are at their most vulnerable. Insurers may worry about adverse selection, which is when people who are more likely to need insurance don't fully disclose their risks. However, the three-year window greatly reduces this risk because it gives insurers plenty of time to do thorough underwriting and research before the policy becomes unchallengeable. The assurance this offers to consumers following three years of punctual premium payments significantly surpasses the reduced risk to the insurer.

B. Strengthening the Regulatory and Redressal Mechanism

1. **Granting the IRDAI additional authority:** The IRDAI requires additional authority to impose substantial punitive damages on insurance companies that are consistently found to be employing unfair claims resolution methods.
2. **Ensuring Ombudsman Awards Are Obligatory:** In order to reduce the frequency of litigation, the Insurance Ombudsman should establish a prompt process for enforcing the awards against insurance companies.

VIII. CHAPTER VI: CONCLUSION

Social and economic security are fundamentally dependent on insurance contracts in contemporary society, which is characterised by numerous hazards. A pledge to provide assistance during difficult circumstances is made, and millions of Indians strive to fulfil this obligation. The law that controls this promise has been unjust for an extended period, allowing the antiquated doctrine of *uberrimae fidei* to be employed as a weapon against the very individuals it was intended to safeguard. This “*downtrodden concern*” – the family confronted with a catastrophic medical emergency or the devastating loss of a loved one, only to be met with a cold, technical, and frequently unjust refusal from their insurer – represents a significant failure of our legal and regulatory system.

The Supreme Court of India has successfully rectified this historical error by meticulously dissecting the insurer’s strict adherence to the law and incorporating the constitutional principles of individual dignity, fairness, and reason. However, the courts are only able to make a limited impact; the legislature is now responsible for concluding this significant reform. The unfair insurance covenant can be modified by Parliament by altering the duty to disclose, incorporating a statutory proportionality test, and extending non-negotiable consumer protections to health insurance. This is not merely a matter of amending contracts; it is a constitutional obligation. It aligns the law with the principles of equality outlined in Article 14 by resolving the power imbalance between the individual and the corporation. It also maintains the commitment to social and economic justice that was established in the Preamble and

Directive Principles. The new set of laws that Parliament can and should enact will ensure that insurance is a guarantee of safety and that the law is used to assist individuals who are in distress, rather than exacerbating their difficulties.

The industry and consumers should be prepared for a seamless transition by carefully planning the implementation of these legislative changes. A proposed implementation timeline of 12 to 18 months from the date of enactment would provide insurers with sufficient time to rewrite policy documents, retrain underwriting staff, and modify the internal operations of claims management. Additionally, transitional provisions would be crucial. All new policies that are issued after the start date should be subject to the new “*duty of fair presentation*” and proportional remedies. The longer period of time during which health insurance cannot be contested should commence three years after the policy is established or when it is next renewed, whichever occurs first, for policies that are already in place. In this manner, the transition will be transparent and predictable for all parties.

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