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Policy Continuity and Premium Restitution in Indonesian Insurance Avoidance Disputes

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ABSTRACT: An insurer's allegation of nondisclosure can unsettle a policy before a court determines whether avoidance is justified. Constitutional Court Decision Number 83/PUU-XXII/2024 restricts unilateral avoidance under Article 251 of the Indonesian Commercial Code. The position of premiums, continuing obligations, and unpaid benefits during the resulting dispute requires a separate private law analysis. This article examines that interval through doctrinal research combining statutory interpretation, close reading of the decision, and a focused review of insurance scholarship. A limited comparison with the United Kingdom's consumer insurance legislation tests the relationship between procedural safeguards and substantive remedies. The analysis distinguishes policy avoidance from claim rejection, suspension, expiry, and nonrenewal. It develops a proposed approach under which a disputed policy remains the reference point for contractual performance until an effective agreement or judicial determination changes its status. That approach does not establish an automatic entitlement to every claimed benefit. Premium collection requires an intelligible account of the protection offered; refund entitlement requires separate examination of good faith, the period of risk, and the legal basis for retention. The article proposes a reasoned notice, preservation of underwriting evidence, a documented premium arrangement, and an express financial account at settlement or judgment. These measures are presented as interpretive and regulatory proposals rather than remedies already ordered by the Constitutional Court. The contribution lies in connecting control over avoidance with the allocation of contractual risk and money during the dispute itself.

KEYWORDS: Insurance avoidance; policy continuity; premium restitution; nondisclosure; Indonesian private law; consumer protection.

I. INTRODUCTION

A policyholder who disputes an allegation of nondisclosure faces a practical question before the legal argument reaches a courtroom: what happens to the policy in the meantime? Premiums may still fall due. A hospital may ask whether an existing guarantee remains available. A beneficiary may have submitted a claim whose payment depends on the validity of an earlier application. Treating the dispute as a question about the eventual power to cancel the policy leaves these immediate obligations unresolved. A meaningful private law response must explain the relationship between the contested contract and the money collected under it.

Indonesia's Constitutional Court addressed the authority to avoid insurance in Decision Number 83/PUU-XXII/2024, pronounced on 3 January 2025. Its conditional interpretation of Article 251 of the Commercial Code requires agreement between insurer and insured or a court decision for avoidance. The decision retains the relevance of good faith. It does not provide a complete procedure for managing premiums and claims throughout a contested case [1; 2]. The distinction between that holding and its possible contractual implications forms the starting point of this article.

The underlying petition was brought by Maribati Duha in connection with a life insurance dispute involving PT Prudential Life Assurance. The record describes the applicant's position as an heir of a beneficiary and the applicant's complaint about an unpaid portion of insurance benefits. Those statements explain the constitutional challenge; they are not treated here as a final determination of the insurer's civil liability. The Constitutional Court reviewed a statutory norm. It did not adjudicate every element of the underlying payment claim [1, paras. 3.5 and 3.7].

That jurisdictional distinction matters. An article can correctly identify stronger protection against unilateral avoidance yet incorrectly assume that every outstanding insurance claim became payable on the day of the constitutional judgment. Payment

still depends on the relevant policy, the insured event, the claimant's entitlement, applicable exclusions, and proof. An insurer can also misuse the distinction by describing a decision as claim rejection while treating the entire contract as if it had never existed. The legal consequences of an act deserve closer attention than the label placed on a letter.

The literature already contains substantial discussion of the judgment. Hernoko and colleagues examine the interpretation of voidness and argue for reform of Article 251 [14]. Prayoga and colleagues address the decision's legal basis and implications for unilateral cancellation [15]. Zuhairi investigates the continuing force of utmost good faith [16]. These studies establish a clear basis for further work. A claim that the judgment has never been studied would be inaccurate.

More recent scholarship approaches adjacent questions. Go Chin Tjwan, Ang, and Lianto consider health insurance cancellation and nonrenewal [17]. Yuda and Kamal discuss claims procedure and proof [18]. Rimbun and Sativa emphasise differences between claim rejection and avoidance when comparing judicial decisions [19]. The present article asks a narrower question: how should the continuing contract and its financial account be handled between the first disputed avoidance notice and an effective resolution? Its contribution is an integrated treatment of that interval, with a particular focus on premiums received, premiums refused, and the distinction between restitution and payment of insurance benefits.

The issue belongs to Indonesian private law even though a constitutional decision supplies the immediate occasion for analysis. An insurance policy creates obligations concerning risk, payment, disclosure, and performance. Disagreement over those obligations engages the Commercial Code, the Civil Code, consumer legislation, and financial services regulation. The Insurance Law, as amended through Law Number 4 of 2023, supplies the sectoral setting [4; 5]. None of these sources should be used as a substitute for identifying the particular obligation that has allegedly been breached.

Two different dangers arise during a dispute. An insurer may stop meaningful protection while continuing to collect premiums. A policyholder may assume that objecting to avoidance excuses all further payment. Both positions can create a new conflict distinct from the original nondisclosure allegation. A court examining the matter months later may face an unclear payment history, overlapping grounds of termination, and uncertainty over the dates on which the parties considered cover to exist. This article develops a proposed presumption of contractual continuity. The disputed contract remains the reference point for performance until an effective legal act changes its status. Continuity is used in a limited sense. It does not extend an expired term, erase a valid exclusion, guarantee renewal, or predetermine a disputed claim. It requires the party seeking a departure from existing obligations to identify a lawful basis, explain its consequences, and preserve a reviewable record. The proposal is supported through a systematic reading of the legal framework, rather than attributed to an express interim order in the Constitutional Court's judgment.

Premium restitution requires an equally careful approach. Returning premiums cannot, by itself, prove that avoidance was valid. Keeping premiums cannot, by itself, prove that the insurer accepted every risk alleged by a claimant. The financial account follows from the legally established status of the contract, the period during which risk was borne, the parties' conduct, and any applicable statutory exception. Confusing those questions produces either an unjustified forfeiture of money or an assumption that a person received free insurance throughout the dispute.

The inquiry addresses three questions. What distinguishes avoidance from other decisions affecting an insurance relationship? Which obligations should guide the parties while avoidance is contested? How should a settlement or judgment account for premiums and benefits without treating a refund as a substitute for a valid legal basis? The proposed answers aim to make the constitutional restriction workable within ordinary contractual relationships. They do not depend on an empirical claim that a particular insurer routinely engages in any identified practice.

II. RESEARCH METHOD

This study uses doctrinal legal research. Its object is the relationship among legal rules, judicial reasoning, and the remedies available in an insurance dispute. Hutchinson and Duncan explain why doctrinal work should make its method explicit rather than leave the movement from legal materials to conclusions implicit [13]. The present analysis identifies the controlling norm, distinguishes different sources of authority, and tests a proposed reading against competing contractual interests. No interviews, survey responses, claims files, or original litigation statistics are used.

The principal case material is Constitutional Court Decision Number 83/PUU-XXII/2024. The analysis separates the applicant's allegations, submissions recorded in the case, the Court's reasons, and the operative ruling. The Court's official summary assists orientation but does not replace the judgment. Particular attention is given to the reasoning on insurance agreements and good faith in paragraphs 3.18 and 3.19. An argument appearing in the extensive record is not attributed to the Court merely because it is reproduced within the decision.

The statutory materials comprise the Commercial Code, relevant provisions of the Civil Code, the Insurance Law and its 2023 amendments, the Consumer Protection Law, and the 1945 Constitution [2–6; 11]. Financial services regulation supplies the

provisions concerning standard agreements, policy content, and dispute resolution [7–9]. The Supreme Court's mediation regulation supplies the judicial mediation context [10]. The study concentrates on conventional consumer insurance. Sharia insurance, compulsory schemes, reinsurance, and insolvency distribution raise additional rules outside its principal scope.

Sources were retrieved through official legal repositories, regulatory websites, journal publication pages, and academic repositories. Searches conducted on 26 September 2026 used the case number and combinations of Article 251, insurance avoidance, premium refund, cancellation, nondisclosure, and their Indonesian equivalents. Targeted searches within the IJMRA domain did not identify an article addressing the precise combination developed here. This was a focused search of accessible indexed material, not an exhaustive review of all journals or unpublished manuscripts. The novelty claim concerns the analytical contribution, not an assertion of absolute priority.

The literature review is selective. It includes research directly concerned with the constitutional decision, related insurance remedies, or the institutional setting of financial dispute resolution. Each study is used for the proposition it actually advances. A published abstract supports a description of the study's stated focus; detailed evaluation of an argument requires the relevant text. The article does not infer that a publication ignored a question merely because the question was absent from its abstract. Three interpretive operations structure the analysis. Textual interpretation identifies what a provision expressly regulates. Systematic interpretation considers how that provision interacts with neighbouring rules on agreement, performance, proof, and restitution. Purposive reasoning tests whether a proposed application would preserve or frustrate the protection against unilateral avoidance. These operations can produce a defensible recommendation without converting it into an existing rule. Statements about what an insurer should record, what an interim arrangement should contain, and what a regulator could require are marked accordingly.

The United Kingdom's Consumer Insurance (Disclosure and Representations) Act 2012 is used as a limited comparator [12]. Its treatment of different kinds of misrepresentation illustrates how a legal system can differentiate remedies. The comparison does not assume that British rules govern Indonesian policies or that a procedural restriction in Indonesia imports a foreign proportional payment formula. Functional similarity provides a question to examine; it does not supply domestic legal authority.

Hypothetical examples test the proposed framework. Their facts and amounts are constructed for analysis and are not findings about Maribati Duha's dispute or any other policyholder. The method can reveal an inconsistency between a contractual position and its financial consequences. It cannot establish how often that inconsistency occurs, predict a court's determination in a particular case, or quantify the cost of regulatory reform. Those issues require evidence beyond this study.

III. THE CASE AND ITS PRIVATE LAW SETTING

A. The Scope of the Constitutional Intervention

The constitutional issue concerned a rule capable of being used to end insurance because of inaccurate information or concealed circumstances. The applicant challenged the legal position created by Article 251. A private disagreement over insurance benefits supplied the background to a public law review of the provision. The remedy granted through constitutional review changed the permissible interpretation of the statutory rule. It did not substitute the Constitutional Court for the civil court that would examine an individual policy and the evidence supporting a claim [1].

That distinction also controls how the case should be described. The existence of an allegation does not establish a misleading application. The existence of a constitutional challenge does not establish a wrongful refusal to pay. The legal question examined here remains meaningful without resolving either allegation. The decision makes it necessary to ask how a contested insurance relationship should operate when one party can no longer conclusively determine its termination alone.

The Court's official formulation permits agreement or judicial determination. An agreement reached after the dispute may settle both the status of the policy and the consequences for premiums. A contested assertion that a standard clause already authorised avoidance presents a different problem. Reading every preprinted cancellation clause as sufficient consent to every future application of that clause would substantially weaken the protection created by the judgment. The proper response requires examination of the clause, the identified ground, the circumstances of assent, and the mandatory rules governing consumer contracts.

The article does not claim that all advance agreements concerning termination are invalid. Policies necessarily describe when cover begins and ends. A rule concerning the scheduled expiry of a term has a different function from a provision allowing an insurer to decide conclusively that disputed application information invalidated the contract from inception. The difficulty lies in using a general signature on the policy to resolve a later factual disagreement that the policyholder actively contests.

B. Formation Duties and Performance Duties

Article 251 belongs to the legal treatment of information relevant to the insurer's decision to enter the contract. The Civil Code's provisions on consent and fraud supply neighbouring concepts, while Article 1338 addresses the binding force and good faith performance of agreements [2; 3]. The analytical task is to keep the formation inquiry connected to, but distinct from, the later performance inquiry. A failure concerning precontractual information does not automatically answer every question concerning money collected after the dispute begins.

A disclosure allegation should be reconstructed around a particular communication. The relevant matters include the question put to the applicant, the answer recorded, the information allegedly omitted, the applicant's knowledge, and the importance of that information to the insurer's original decision. Describing a policyholder as lacking utmost good faith adds little unless the contested conduct is identified. A general principle becomes useful in litigation only when it can be connected to evidence and a legally significant consequence. The insurer's conduct also requires examination. Application forms are designed by the provider or its distribution partners. Questions may use technical medical language. Answers may be entered by an intermediary. An applicant may disclose information orally that does not appear in the final form. These are possible evidentiary situations, not assumed facts about the case. They show why a signature should be considered alongside the process by which the signed record was produced.

Good faith cannot be reduced to a demand for favourable behaviour by one side. The insurer seeks reliable information before accepting risk. The consumer needs an intelligible explanation of the questions and the resulting protection. The sectoral framework recognises duties concerning care, information, and claims handling [4; 5]. A systematic analysis should examine both contributions to the quality of the agreement without assuming that imperfect underwriting eliminates the insured person's obligations.

The distinction between knowledge and diagnosis is particularly important in health and life insurance. A later medical document may establish that a condition existed earlier. It does not necessarily establish that the applicant knew the condition at the time of answering a question. A question asking about a diagnosed illness differs from one asking about consultations, symptoms, tests, or medication. The actual wording determines what answer was requested. Retrospective knowledge should not silently replace the knowledge relevant to the application.

C. The Position of Consumer and Regulatory Law

The Consumer Protection Law recognises rights concerning information and remedies and restricts specified forms of standard terms [6, Arts. 4, 7, 18 and 19]. These provisions give a private law dispute a wider protective context. They do not remove the need to identify a contractual breach, an unlawful act, or another legal basis for the particular relief claimed. A claimant seeking the policy benefit is asking for something different from the return of an improperly retained premium or compensation for a separate loss.

OJK Regulation Number 22 of 2023 addresses prohibited standard clauses and access to contractual documents. Articles 46 and 47 are relevant to an avoidance dispute because the content of the agreement and the consumer's ability to obtain it shape the dispute from its beginning [7]. OJK Regulation Number 8 of 2024 requires insurance policies to state specified matters, including the period of cover, benefits, exclusions, premium arrangements, and relevant termination provisions [8, Art. 12]. These requirements support clear drafting; they do not by themselves validate every clause appearing in a policy.

Regulatory compliance and civil validity should be assessed separately. A product may have passed a regulatory process yet generate a dispute over the application of a clause to particular facts. A provider may breach an administrative requirement without causing the whole amount of a claimed civil loss. The existence of oversight provides neither blanket immunity nor an automatic damages award. The article's proposed account of continuity relies on the contract and the applicable law, with regulatory procedures supporting their effective operation. The same discipline applies to constitutional language. Fair legal certainty under Article 28D paragraph (1) informs the framework in which statutory insurance rules operate [11]. It does not eliminate the distinctions among formation, performance, and remedies. The practical value of constitutional protection depends on those distinctions being translated into decisions that parties can understand and implement.

D. What Remains Undetermined

The constitutional ruling leaves room for disagreement over the financial effects of an eventual avoidance decision. A civil court may need to determine the relevant effective date, the status of benefits already paid, the treatment of premiums, and the consequences of proven misconduct. Those matters should be pleaded and supported. A judgment declaring a policy invalid without explaining the associated monetary obligations risks producing a second dispute about execution.

An open question is not a legal vacuum. Existing rules still govern agreement, payment, evidence, good faith, and remedies. The proposed framework uses those rules to organise the dispute rather than suggesting that insurers and policyholders must

await a wholly new statute before acting. Its limits are equally important: a general argument for continuity cannot guarantee the availability of a particular provisional court order or override a special rule applicable to a specific insurance product.

IV. DISTINGUISHING AVOIDANCE FROM OTHER INSURANCE DECISIONS

A. Legal Effects as the Basis of Classification

Insurance correspondence often uses cancellation, rejection, termination, and lapse without explaining their different consequences. Careful classification begins with two questions. Does the insurer accept that a valid policy exists? Does the decision affect one claimed benefit or the whole contractual relationship? The answers help identify whether the dispute concerns the original validity of the agreement, performance under that agreement, or the end of protection for the future.

Avoidance, as used in this article, concerns a challenge to the policy's validity arising from a defect associated with entering the agreement. Prospective termination concerns the ending of obligations from a specified point onward. Claim rejection concerns a particular demand for payment. Expiry concerns the completion of an agreed term. Nonrenewal concerns the absence of a further term. Suspension concerns the temporary withholding of a contractual function. These working definitions organise the analysis; the applicable Indonesian rule and the policy wording determine the consequences in an actual dispute.

The categories in Table I can overlap in a single letter. An insurer might reject a hospital claim, assert that the policy was void from its beginning, offer a premium refund, and state that future premiums will no longer be accepted. The legal analysis should address each asserted consequence. A heading describing the letter as a claims decision cannot insulate an accompanying avoidance decision from the requirements applicable to avoidance.

The reverse mistake is also possible. An insurer may reject one item that falls outside a valid policy while continuing all other protection. Treating that decision as avoidance would extend the constitutional rule beyond its subject. Rimbun and Sativa's emphasis on distinguishing rejection from cancellation supports a careful examination of consequences rather than terminology [19]. A sound classification protects the policyholder from disguised avoidance while preserving legitimate evaluation of the benefits actually promised.

Table I Legal Effects of Different Insurance Decisions

Decision	Central question	Effect that requires explanation
Avoidance	Was the agreement affected by a relevant formation defect?	Effect on contractual validity and the resulting financial account.
Claim rejection	Is the particular benefit due under a valid policy?	The identified benefit may be disputed while other cover continues.
Lapse	Did nonpayment produce the asserted contractual result?	Due dates, payment attempts, acceptance, and any applicable conditions.
Expiry	Has the agreed term ended?	Future cover and rights arising within the earlier period must be separated.
Nonrenewal	Was a further term promised or required?	The future relationship must be distinguished from accrued claims.
Suspension	What permits the temporary withholding of performance?	The obligation affected, its legal basis, and the period of the restriction.

Source: Author's analytical classification based on [1–3, 7–8]. The table does not prescribe identical consequences for all products.

B. Claim Rejection under an Existing Policy

A valid insurance agreement does not require payment of every expense or loss claimed by its holder.

The benefit may have a defined limit. The insured event may not have occurred within the covered period. A claimant may not yet have supplied a necessary document. The insurer must explain the specific reason for its position. The continuing existence of the policy and the enforceability of a particular demand remain separate questions.

Consider a hypothetical policy covering inpatient care but excluding a specified outpatient procedure. A refusal to reimburse that procedure can leave the contract otherwise intact. The relevant inquiry concerns the exclusion, its communication, the facts

of the treatment, and its application. An Article 251 dispute arises if the insurer instead relies on information given before formation to deny the continuing legal force of the agreement. The distinction changes what must be proved and what relief should be requested.

An alleged exclusion can also be used too broadly. A provider may invoke an application discrepancy as a reason to suspend all current and future benefits without formally using the word avoidance. The decision's effect then requires scrutiny. Where the position depends on treating the original agreement as defective, the insurer should not obtain the practical result of avoidance merely by declining to issue a cancellation document. This is an interpretive argument derived from the purpose of the constitutional safeguard, not an assertion that the Court expressly decided every possible suspension practice. Claims administrators should make the basis of a decision visible. A useful notice identifies the claimed benefit, the contractual provision relied upon, the relevant facts, and the effect on other cover. It states whether the decision concerns missing evidence, an exclusion, a financial limit, or an allegation affecting policy validity. Such specificity allows a policyholder to respond to the real issue. It also helps prevent an insurer from defending a payment refusal on a different ground only after litigation begins.

C. Lapse and Refused Premiums

Lapse commonly relates to the consequences of nonpayment under the policy's terms. Its legal operation depends on the agreement and applicable protective requirements. An objection to avoidance does not necessarily excuse the consumer from paying a premium that remains due. A rule that allowed a person to obtain continuing protection merely by filing an objection, without addressing payment, would create an imbalance of its own.

The payment history may reveal a different problem. A policyholder might attempt payment through an established channel after receiving an avoidance notice, only to find that the insurer has disabled the payment facility. A later assertion of lapse for nonpayment then requires scrutiny of that refusal. The provider's decision about accepting payment should not disappear from the factual account. A screenshot, bank record, payment instruction, or written response can help establish what occurred.

The Civil Code contains a mechanism concerning an offer of payment followed by deposit when a creditor refuses performance [3, Arts. 1404–1406]. Its formal requirements matter. A personal transfer into an account chosen by the debtor is not automatically equivalent to a legally effective deposit. The existence of the mechanism supports a limited point: refused payment is a recognised legal problem requiring an appropriate response. It does not justify advising every policyholder to stop paying or to create an informal escrow arrangement.

An interim agreement can address the problem more directly. The parties could identify the payment channel, specify how payments will be recorded, and reserve their positions on the underlying nondisclosure allegation. Such an agreement should also state whether and how ordinary policy charges continue. The arrangement requires a legal basis in consent or an available order. An academic recommendation cannot confer authority on a provider to hold money under terms the consumer never accepted.

D. Expiry and Nonrenewal

An agreed policy term may end while a dispute about an earlier claim remains unresolved. Preserving the historical claim does not necessarily extend cover into a new term. The date of the insured event, the date of notification, the contract's duration, and any applicable reporting provisions need separate attention. A benefit arising during an existing term should not be treated as extinguished solely because the policy later reached its scheduled endpoint.

Nonrenewal introduces a further distinction. A refusal to offer a future policy may be governed by an existing renewal promise, product regulation, or the circumstances of the decision. The argument advanced here does not establish a universal duty to renew. Go Chin Tjwan and colleagues take a protective approach to unilateral nonrenewal in the context they examine [17]. This article confines its continuity proposal to the existing relationship and the preservation of accrued rights. Extension into a new period requires its own legal analysis. The reason for nonrenewal still deserves examination. Relabelling retrospective avoidance as a refusal to renew should not defeat a claim arising during the earlier period. An insurer that accepts the earlier policy's validity but declines a new term presents a different position from one that uses nonrenewal correspondence to recover benefits already paid. A court should require the party advancing the position to explain its temporal scope.

E. Suspension and the Risk of an Indefinite Dispute

Suspension can have consequences as serious as formal termination. A policy described as active may be of little practical value if every request for a guarantee or reimbursement is placed on hold indefinitely. The legitimacy of a particular delay depends on its legal basis, the information needed, the benefit concerned, and the applicable procedure. The term under review should not function as an unlimited exemption from performance.

A reasoned investigation can be legitimate. Relevant records may be incomplete. A claimant may need to establish entitlement. Serious discrepancies may require explanation. The proposed continuity approach accommodates those circumstances by

separating preservation of the contractual relationship from immediate payment of a disputed benefit. It asks the insurer to identify the unresolved issue and its consequences rather than to announce a final result before a contested avoidance has been lawfully resolved.

The person reviewing the dispute should also ask whether an undisputed component can be decided separately. A disagreement about one benefit does not necessarily justify withholding an unrelated amount that the insurer accepts is due. Any partial payment needs a clear description of what it settles. A payment made toward an accepted component should not silently operate as a release of the disputed balance.

V. CONTRACTUAL CONTINUITY DURING A CONTESTED AVOIDANCE

A. A Rebuttable Starting Position

The proposed continuity approach starts from the agreement the parties made. An allegation that the agreement should be avoided does not supply its own conclusive proof. The insurer remains entitled to present the allegation through the appropriate process. The policyholder remains responsible for obligations that have not been lawfully displaced. The approach gives neither side an unrestricted right to determine the other's position.

Its legal justification rests on the interaction between contractual binding force and the restriction on unilateral avoidance. Article 1338 of the Civil Code provides the general contractual setting [3]. The constitutional ruling limits how the insurer may obtain the particular consequence associated with Article 251 [1]. Reading the two together supports using the existing agreement as the reference point while the asserted ground of avoidance is contested. The precise treatment of individual obligations may still depend on a valid clause, an agreed arrangement, a special rule, or a court's decision.

Continuity is rebuttable in that qualified sense. The proposal does not declare an indefinite right to all services under every disputed policy. It requires a specific explanation for a departure from the contractual position. A party relying on an independent ground of expiry or nonpayment must establish that ground. A party requesting provisional relief must identify an available procedural basis. The constitutional judgment alone should not be described as an injunction automatically issued in every later insurance case.

An objection deserves a documented response even where the insurer regards its evidence as strong.

The record should show whether the consumer contests the alleged inaccuracy, its relevance, responsibility for the recorded answer, or the proposed consequence. Those objections can differ substantially. A consumer may accept that a date was recorded incorrectly while denying that it could justify destruction of the entire insurance relationship. A response that repeats the words material nondisclosure without addressing the objection fails to clarify the dispute.

B. Notice before a Disputed Consequence Is Implemented

A useful avoidance notice performs more than an administrative function. It connects the insurer's factual allegation to the contractual result sought. The proposed notice should identify the relevant application question and recorded answer, explain the alleged discrepancy, state why it mattered to the original underwriting decision, and describe the intended effect on the policy and its financial account. The recipient should be able to understand what needs to be disputed without first reconstructing the insurer's reasoning through litigation.

The notice also needs temporal precision. Avoidance from inception, termination from a future date, and rejection of a single claim produce different accounts. A letter that does not distinguish them can mislead both the consumer and the employees handling subsequent payments. The relevant date should be tied to a stated legal position. A date selected for administrative convenience should not silently determine when contractual obligations ended. An insurer may need to protect confidential underwriting methods. That interest does not necessarily justify withholding every explanation of materiality. A meaningful response can identify the applicable underwriting consideration and its proposed consequence without publishing the provider's entire pricing model. Where disclosure of a particular document is contested, the available procedural safeguards should be considered. The article proposes a duty of reasoned explanation; it does not assume an unrestricted consumer entitlement to every internal record.

A notice should make clear whether a refund is an offer requiring agreement or a payment the insurer contends is already due. It should avoid language suggesting that merely receiving money in a bank account conclusively proves acceptance of avoidance. The legal significance of subsequent conduct depends on the facts. A consumer who promptly objects to an unsolicited refund presents a different situation from one who knowingly signs a negotiated settlement specifying that refund as final resolution.

C. Premium Collection under Reservation

Continuing premium collection during a dispute is defensible only if the insurer explains the contractual position associated with it. A provider should not rely on the consumer's payment as performance while simultaneously asserting, without

qualification, that it bears no contractual risk at all. The point is one of consistency and accounting. It does not mean that accepting any payment necessarily waives every defence. An express reservation can clarify that a payment is accepted while a stated issue remains unresolved. Its wording should be intelligible to the consumer. It should identify how money will be allocated and what the parties understand about continuing protection. A unilateral statement that the insurer may keep all funds regardless of the outcome would raise a different question under the applicable contract and consumer rules. The label reservation of rights does not settle the validity of its content.

The policyholder's position needs similar clarity. Payment during a dispute should not automatically be treated as an admission that the insurer's accusation is correct. A person may pay to avoid a separate nonpayment problem while maintaining an objection to avoidance. Written communication can preserve that distinction. The legal assessment should examine the conduct as a whole, including the payment instruction and the contemporaneous objection.

Products with investment components require particular caution. A total payment may be allocated among risk cover, investment units, and charges. A promise to return the premium can conceal a disagreement over what the term includes. This article does not supply a universal valuation method for investment linked insurance. It proposes that each component be separately identified before settlement, with the valuation date and contractual basis disclosed. Ordinary premium arithmetic cannot resolve a product whose account depends on additional features.

The insurer's internal system should preserve the history of any status change. Replacing an earlier active record with a void entry can make it difficult to reconstruct what information was visible when the consumer paid or sought treatment. A dated history of the change, its authorisation, and its stated reason would assist review. This is an operational recommendation aimed at evidentiary clarity. It does not assume that every existing system lacks such a history.

D. The Treatment of Claims Arising during the Dispute

A claim arising after the avoidance allegation but before its resolution requires its own analysis. The fact that a dispute exists does not establish that the insured event occurred outside valid cover. The eventual treatment may depend on the outcome of the validity dispute and on the policy's ordinary conditions. A reasoned claims response should identify both issues instead of merging them into a general statement that the matter is under investigation.

The proposed approach distinguishes processing from payment. The provider should continue receiving and preserving documents relevant to a claim. It should identify any missing material and record the date on which the claim became sufficiently complete for the applicable process. Whether immediate payment is due can remain contested. Refusing to accept the claim at all may destroy evidence or create a later argument about late notification that was caused by the refusal itself.

Urgency strengthens the need for a clear response. A prospective medical guarantee can determine whether treatment is arranged through a particular provider, while reimbursement usually follows expenditure already incurred. The article does not equate the two. An interim arrangement should specify which service is requested, which party bears the immediate financial exposure, and whether any later repayment is contemplated. An unsupported promise of automatic coverage could expose the consumer to further loss.

Any proposed recoverable advance needs a separate legal basis and clear terms. The parties might agree to an interim payment without admitting the final validity of the policy. They would need to specify the consequences of each possible outcome and avoid an open ended obligation that the consumer cannot evaluate. A court may consider provisional relief only within its lawful procedural powers. The present proposal is directed at the structure of the issue, not a claim that such relief is universally available.

E. Evidence Preservation as a Continuing Obligation

The original underwriting file can become more important after a claim than it appeared when the policy was sold. Relevant material may include the proposal form, the version of each question, amendments, medical authorisations, correspondence, and the record of the insurer's decision. A later printout may not show what appeared on the application screen at the time. Preserving the version and date can be as important as preserving the final answer. The general burden of proof under Article 1865 of the Civil Code remains relevant to the party asserting a right or fact [3]. Consumer law can impose specific rules concerning proof within its scope [6, Art. 28]. Neither proposition supports the statement that the constitutional decision transferred every evidentiary burden to the insurer. The allocation depends on the issue and the legal cause of action. The consumer still needs to establish matters supporting the claimed benefit; the insurer needs to substantiate the defence it advances.

Yuda and Kamal place evidentiary demands at the centre of their account of the judgment's implications [18]. The contribution developed here concerns the quality of the account preserved before the case reaches that evidentiary stage. A disputed answer is easier to evaluate when the insurer can identify the original question, the source of its alleged correction, and the underwriting consequence asserted. Better records benefit an insurer with a meritorious defence as well as a consumer facing an unsupported allegation.

Evidence preservation should include material favourable to either position. A sales recording that supports the consumer may sit within the provider's system. A medical document contradicting the application may be held by the claimant. The proposed process should request relevant material through lawful channels and protect information unrelated to the dispute. The need for evidence does not justify unrestricted access to a person's entire medical history or disclosure to staff who have no role in deciding the matter.

F. Protection against Strategic Delay

A continuity proposal can be abused if a party extends the dispute while obtaining all of its advantages. A consumer might withhold documents that are reasonably needed. An insurer might issue repeated generic requests to postpone a final position. The proposed framework should link requests to identified issues and require the parties to record what remains outstanding. A refusal to provide a relevant item should be distinguishable from an objection to a request that has no explained connection with the claim.

OJK Regulation Number 22 of 2023 sets time requirements for responding to complaints, including the period for a written complaint once the required documents are complete and the conditions for an extension [7, Art. 75]. A complaint response deadline is not necessarily the same as the maturity date of an insurance benefit. Keeping the two clocks separate avoids the assumption that every complaint deadline creates an automatic duty to pay the sum demanded.

The article recommends a dated notice whenever the provider changes its position or requests further documents. The notice should explain whether the request affects the complaint process, the claim decision, or a proposed avoidance. A periodic status report would allow a mediator or court to see whether delay arose from a genuine evidentiary problem or from an unresolved administrative step. The recommended record should be proportionate to the case, with a simpler form for routine disputes.

VI. PREMIUM RESTITUTION AND THE SELECTION OF CIVIL REMEDIES

A. A Refund Is a Consequence That Requires a Basis

Restitution concerns the return of a transfer when the recipient lacks the relevant basis for retaining it. In an insurance dispute, the analysis begins by identifying the payment and the legal relationship under which it was made. A premium for a period of risk differs from a deposit, a policy fee, an investment allocation, or an amount paid by mistake. Referring to every transfer as a premium can obscure the applicable rule.

Article 281 of the Commercial Code connects whole or partial premium return with the termination or invalidity addressed by the provision, good faith, and the extent to which risk was not borne. Article 282 treats avoidance attributable to specified wrongful conduct by the insured differently [2]. These provisions prevent a simple universal formula. The financial consequence needs findings concerning the legal ground, the parties' conduct, and the relevant period. Their application should not be inferred solely from the insurer's initial allegation. A dispute can contain two independent questions: whether the policy was effectively avoided and whether a particular amount may be retained. An insurer may offer a refund to encourage settlement. The offer does not establish the first question. A policyholder may demand the return of money collected for a period during which the insurer denies any obligation. The demand does not necessarily concede every allegation about the original application. The legal meaning of the request must be assessed in its context.

Hernoko and colleagues' discussion of voidability helps explain why the legal act changing contractual status deserves attention [14]. Once the status is resolved, the financial account still requires work. A finding concerning defective consent should not leave the parties to guess which payments must be returned, which obligations survive, and whether a previously paid benefit is affected.

B. Separate Accounts for Different Periods

A useful financial reconstruction distinguishes the period before the disputed notice, the period while the dispute remained open, and any period after effective resolution. These are analytical periods rather than a statutory formula. Their purpose is to expose a mismatch between the risk position asserted by a party and the treatment of money during the same time. A provider may have accepted an earlier period of cover while rejecting responsibility only from a later date.

The reconstruction should identify the date and purpose of every relevant receipt. It should separately show refunds, ordinary policy charges, and benefits already paid. A bank transfer may cover several instalments. A debit may be reversed. A payment may have been attempted but rejected. The totals become meaningful only after the underlying entries are reconciled. In a disputed case, the parties should be able to challenge the classification of an entry without losing access to the rest of the account.

The proposed account also asks what the insurer says it provided in exchange. If the insurer maintains that it bore risk for a particular month, it should identify the contractual position supporting that statement. If it says the policy was ineffective

throughout, retention requires a basis compatible with that position and any applicable exception. The account does not prejudge which position is correct. It prevents contradictory positions from passing unnoticed into the final calculation.

An annual premium should not automatically be divided by twelve.

Some products can support an agreed or legally appropriate time based allocation. Others involve charges, pricing structures, or statutory consequences that require a different method. A proportional calculation is justified only after the basis for that allocation is established. The simplicity of arithmetic cannot supply a legal premise that the parties dispute.

C. Worked Illustrations of the Financial Account

The following examples are hypothetical and concern a simple risk only policy. They assume facts for the purpose of testing the analysis. None reproduces the amounts or outcome of the constitutional applicant's dispute. The figures illustrate why the financial consequence follows from the legal findings rather than from the existence of an allegation alone.

Table II Hypothetical Premium Accounts

Illustration	Assumed facts	Result of the analysis
Agreed prospective end	IDR 12,000,000 annual premium; four months of cover; agreed monthly allocation.	IDR 8,000,000 refund under the stated agreement.
Receipts during dispute	Three further payments of IDR 1,000,000 after a contested notice.	IDR 3,000,000 must be classified; return or retention depends on the established basis.
Unsolicited refund	IDR 6,000,000 transferred; IDR 100,000,000 benefit remains disputed.	Receipt alone does not settle validity, benefit entitlement, or adjustment.

Source: Author's constructed examples. The figures are illustrative and are not amounts established in Decision Number 83/PUU-XXII/2024.

In the first example, the annual premium is IDR 12,000,000. The parties validly agree to end the policy after four months of accepted cover and agree that the unused part will be returned on a monthly basis. Eight months remain. The agreed calculation produces a refund of IDR 8,000,000. The result follows from the stated assumptions, including the accepted four months of cover and the agreed method. It is not a general statutory entitlement for every annual insurance policy.

In the second example, the insurer alleges that the contract was defective from inception, then collects IDR 1,000,000 per month during a three month dispute. The resulting IDR 3,000,000 requires an express treatment in the final account. A court or settlement may ultimately recognise cover during the relevant period, require return on an established basis, or apply another lawful consequence supported by its findings. Calling the money nonrefundable before those issues are resolved would assume the answer. In the third example, an insurer transfers a refund of IDR 6,000,000 without a settlement signed by the policyholder. The policyholder objects to avoidance and seeks payment of a claimed benefit of IDR 100,000,000. Receipt of the refund does not mechanically decide the claim. The adjudicator must examine consent, the policy's status, the benefit's conditions, and the legal treatment of the transferred amount. Any set off or repayment must be justified. The example does not establish that the claimant can retain both amounts without adjustment.

These examples reveal a recurring analytical error. A party may start with a preferred figure and construct the policy's status around it. The proper sequence is to determine the legal position, identify the consequences for each payment, and calculate the account. A negotiated settlement may adopt a compromise amount, but it should state that it is a compromise rather than present the figure as the unavoidable result of a rule that does not prescribe it.

D. Restitution and the Policy Benefit

A policyholder who insists that the agreement remains valid will usually focus on performance of the promised benefit. A person who accepts or obtains avoidance may instead seek return of money. These remedies reflect different premises. Alternative pleading can preserve a position where the validity question remains unresolved, subject to the applicable procedural rules. The requested relief should make the relationship among alternatives intelligible.

The court should avoid double recovery for the same economic interest. A claimant may have distinct entitlements that can coexist, such as an accepted policy benefit and compensation for a separately established loss. A premium refund and full enforcement of the same period of cover can create a different issue. The legal basis and the account must explain the relationship. A general invocation of consumer protection cannot substitute for that explanation.

Article 1267 of the Civil Code provides a contractual remedial setting, while the provisions on default and compensation require their own conditions to be considered [3]. A claim for the insured sum, a claim for a late payment loss, and a claim to reverse an unsupported debit should not be merged into one unparticularised demand. Identifying each head of relief makes the defendant's response and the eventual order more precise.

The possibility of an unlawful act claim requires similar care. Articles 1365 and 1366 provide relevant general provisions, but a disputed insurance decision does not automatically establish every element of liability [3]. The alleged conduct, fault, loss, and causal connection need examination. Where the dispute is framed contractually, the claimant should explain why an additional basis is relevant and how the requested compensation avoids duplication. This article does not assume that every breach of an insurance agreement should be relabelled as a tort.

E. Proven Fraud and the Limits of Protection

Procedural protection should remain available even where an insurer alleges serious dishonesty. The need to establish misconduct is especially important because the consequences for premiums may differ. Article 282 should not be treated as a licence to retain money whenever the word fraud appears in correspondence [2]. A legally relevant finding or effective agreement must connect the alleged conduct to the consequence claimed.

The insured person's deliberate concealment can materially prejudice underwriting. A protective framework must preserve an effective remedy for that situation. Zuhairi's account of continuing good faith obligations is relevant here [16]. The constitutional restriction concerns control over avoidance; it does not make accurate information optional. A policyholder who benefits from a fair process remains subject to the outcome that the applicable law supports.

The insurer should also separate fraud from ordinary disagreement about wording. An ambiguous question, a mistaken date, an intermediary's transcription error, and a deliberately false statement may require different findings. The seriousness of a later claim does not transform every earlier error into dishonesty. The proposed framework insists on identifying the conduct before selecting its consequence. It allows a strong defence to succeed on its evidence without making suspicion conclusive.

F. Set Off and Benefits Already Paid

An insurer seeking to recover benefits already paid must identify the legal basis for recovery.

The existence of an avoidance dispute does not automatically authorise deductions from any money connected with the policyholder. The parties may disagree over whether the benefit was due, whether the payment was final, and whether the recipient acted in good faith. These questions require examination before a net figure can be presented as settled.

Set off also depends on legal conditions. A provider should not equate its own calculation of a disputed repayment with an established debt available for automatic deduction. The proposed financial account should show a claimed recovery separately from an amount already agreed or adjudicated. That distinction allows the court to determine each item without obscuring the consumer's original claim.

A settlement can expressly resolve reciprocal monetary positions. It should identify the benefit paid, the amount to be returned if any, the remaining premium balance, and the scope of the release. The settlement should state whether it resolves only the existing dispute or also future obligations under a continuing policy. Vague language about full settlement may produce a new disagreement when another event later arises.

G. Interest and Consequential Loss

Delay may cause a financial loss beyond the unpaid policy benefit. A claimant may assert borrowing costs, an additional medical expense, or another consequence of nonpayment. The asserted loss requires a legal basis and evidence of causation. It should not be presumed merely because the insurer ultimately loses the validity dispute. The date on which payment became due and the requirements concerning default can be central to the analysis.

Interest should be identified as a separate head of relief. The applicable rate, starting date, and basis cannot be chosen simply to make a remedy appear substantial. A settlement may agree those matters. A judgment must derive them from the applicable legal and factual position. The financial account should distinguish the principal amount from any interest or compensation so that enforcement does not depend on an unexplained aggregate.

The same caution applies to reputational or emotional harm. Insurance disputes can be distressing, but a doctrinal article should not turn that observation into an automatic damages entitlement. The proposed framework concentrates on preserving the evidence needed to evaluate a claim and on articulating the relevant remedial premise. It leaves assessment of particular nonpecuniary claims to the governing law and the facts proved.

VII. IMPLEMENTATION THROUGH COMPLAINTS AND DISPUTE RESOLUTION

A. The Internal Complaint as an Opportunity to Define the Dispute

Internal complaint handling is useful when it produces an answer to the objection actually raised. Repeating the initial avoidance letter adds little where the consumer has supplied contrary evidence or challenged the interpretation of a question. A meaningful review should identify whether the original conclusion remains supported and explain the treatment of each material response. A separate reviewer may improve the process where the initial decision is itself contested.

The proposed internal record should contain a concise chronology, the relevant policy version, the application material, the grounds relied upon, and the payment account. It should identify the relief requested by the consumer. A request to restore a policy, a demand for a particular benefit, and an objection to an unexplained deduction can require different responses. Combining them into a single category such as rejected claim risks leaving part of the complaint unanswered.

Access to documents is central to that process. A person cannot meaningfully contest a recorded answer without knowing the question and the text attributed to them. The regulatory requirement to provide access to standard contractual documents is relevant [7, Art. 47]. The proposed process would extend the practical explanation to the specific application record used as the basis for avoidance, subject to lawful limits concerning third party information and confidential material.

An internal response should state what remains contested after review. If the insurer accepts that a recording error occurred but maintains a different defence, the revised position needs to be communicated. If the insurer accepts that a benefit is payable, the payment and any residual dispute should be identified separately. Clear issue definition reduces the risk that mediation begins with the parties discussing different decisions.

B. Mediation and an Effective Settlement

OJK Regulation Number 61/POJK.07/2020 provides the institutional framework for the financial services alternative dispute resolution body, LAPS SJK [9]. Ulinihayati and Husein examine its role in insurance disputes [20]. Rama discusses the legal certainty associated with the move toward an integrated institution [21]. These sources establish a relevant setting for negotiated resolution. The eligibility rules and the procedure applicable to the particular dispute still need to be observed.

Mediation can be especially useful where the disagreement concerns several connected matters. The parties may need to decide whether the policy continues, how an earlier claim will be treated, and what happens to money already received. A mediator can help expose the consequences of each proposed settlement. A refund that appears attractive in isolation may have a different significance if it also ends access to a continuing policy that the consumer cannot readily replace. The article recommends that a settlement state the legal status of the policy in direct terms. It should identify the effective date, the treatment of accrued claims, the premium account, and any remaining obligation. A document that states only that the dispute has been settled may be inadequate where later performance still depends on the insurance relationship. Precision is also important for an insurer seeking a reliable end to the controversy.

Consent must be assessed in the circumstances in which it was given.

An offered compromise does not become coercive merely because a party faces litigation costs. A process becomes more concerning where the consumer receives no explanation of an existing right or is told that an unsolicited transfer has already eliminated the right to object. The proposed safeguards are an intelligible account, an opportunity to seek advice, and a clear statement of the release being requested. They help distinguish agreement from administrative acquiescence.

The availability of mediation should not be turned into an unsupported assertion that every form of complaint handling is a mandatory jurisdictional prerequisite to every civil action. The applicable forum rules matter. Court proceedings are also subject to the mediation framework in Supreme Court Regulation Number 1 of 2016, with its specified scope and exceptions [10]. The article uses mediation as a route toward valid agreement and clearer issues, without collapsing internal complaints, institutional mediation, and judicial mediation into one procedure.

C. Judicial Determination and an Executable Order

Where agreement fails, the court needs a dispute that has been properly pleaded. The party seeking avoidance should identify the asserted legal ground and the consequence requested. The party claiming performance should identify the policy obligation and supporting facts. A court cannot reliably calculate the financial outcome from general statements that the insurer acted unfairly or the insured lacked good faith.

The proposed structure of the final determination separates policy status from monetary consequences. It identifies the legal effect of the decision and its relevant date. It then addresses the benefit claim, premiums, and any independently established compensation. Where a claim is dismissed because a particular benefit was excluded, the order should not inadvertently imply that the entire policy was invalid. Where avoidance is granted, the associated financial consequences should be determined to the extent properly claimed and proved.

A chronological account can assist that task. The record should show when the policy began, when the alleged information was supplied, when the insurer learned of the discrepancy, when the claim arose, and when the contested decisions were communicated. This is a recommendation about the presentation of evidence. The mere passage of time does not create a universal waiver rule. Delay can become legally significant only in relation to a relevant provision, agreement, or established argument.

Arbitration raises questions that should not be assumed away. Its availability and effect depend on an effective arbitration agreement and applicable law. The constitutional judgment's reference to courts should not be casually rewritten as a general endorsement of any forum selected by the insurer. This article does not resolve the interaction between arbitral jurisdiction and every possible avoidance claim. Mediation remains analytically distinct because a successful process produces the parties' agreement rather than a unilateral insurer decision.

D. Regulatory Guidance on the Interval before Resolution

Regulatory guidance could make the proposed approach more consistent across providers. A notice standard could require the insurer to identify whether it proposes avoidance, rejects a benefit, or relies on a separate contractual endpoint. A premium statement could explain how funds received during the dispute will be recorded. A requirement to preserve the original application and decision history could support later examination without prescribing the outcome of every case.

The division of institutional responsibility is important. OJK can address conduct within its statutory and regulatory powers. Courts determine civil disputes within their jurisdiction. A regulator's recommended process should not be presented as a substitute for an individual adjudication of policy validity. Legislative changes, including the subsequent amendment of the financial sector framework by Law Number 4 of 2026, also require attention when translating a doctrinal proposal into a binding rule [22].

The recommended measures should be proportionate. A short dispute involving a single instalment does not need the same administrative record as a contested life insurance benefit involving years of payments. The essential information can remain consistent while the level of detail varies. Providers already preserve many relevant records for ordinary business purposes; the proposal concerns connecting those records to a reasoned legal position and a transparent account.

Table III Legal Anchors And Proposed Implementation

Issue	Existing legal anchor	Proposal advanced in this article
Contested avoidance	Article 251 as conditionally interpreted in Decision 83/PUU-XXII/2024.	Identify the legal consequence sought and respond to the material objection.
Policy documentation	POJK 8/2024, Article 12; POJK 22/2023, Articles 46–47.	Provide a reasoned notice tied to the policy and application record.
Premium treatment	Civil Code payment rules; Commercial Code, Articles 281–282.	Record payments and risk periods separately; agree or obtain a lawful basis for interim arrangements.
Evidence	Civil Code, Article 1865; relevant consumer proof rules.	Preserve the original questions, answers, decision history, and material underwriting evidence.
Resolution	Applicable agreement, mediation, and adjudication rules.	Specify policy status, effective dates, benefits, refunds, and distinct compensation in the final account.

Source: Author's synthesis. The final column contains recommendations, not additional orders made by the Constitutional Court.

Table III distinguishes legal anchors from recommendations so that a useful administrative practice is not mistaken for an existing judicial command. The notice and accounting proposals can be adopted through properly drafted agreements and internal processes where lawful. Measures requiring compulsory disclosure, special custody of money, or a new remedial power need a sufficient legal basis. Clear implementation should improve the operation of current protections without claiming powers that an institution does not possess.

VIII. COMPARATIVE INSIGHT AND LIMITS OF THE PROPOSED APPROACH

A. The Distinction between Procedure and Substantive Remedy

The United Kingdom's 2012 consumer insurance legislation provides a useful contrast. It centres the consumer's duty on reasonable care concerning representations. It differentiates deliberate or reckless misrepresentation from carelessness and links specified remedies to what the insurer would have done with correct information. Schedule 1 permits different consequences, including avoidance in specified circumstances and adjustment where different terms or a higher premium would have been used [12, ss. 2–5 and Sch. 1]. The value of this comparison lies in the separation of questions. A legal system must decide who can establish a disputed ground and what consequence follows once that ground is established. Requiring a court to decide avoidance addresses authority and process. Differentiating the consequence of a minor error from deliberate deception addresses substantive remedial design. One type of reform does not necessarily perform the work of the other.

Indonesia's constitutional decision should not be described as introducing the British statute's entire remedial structure. Article 251 and the surrounding domestic rules remain the starting point. A foreign proportional reduction formula cannot be applied simply because it appears fair in a hypothetical example. Reform would require attention to the Indonesian legal basis, the relevant products, the information available to applicants, and the way a counterfactual underwriting decision could be proved.

The comparison also suggests a question for future legislative work. If reliable evidence shows that accurate information would have led to a different premium rather than a refusal to insure, should the legal consequence differ from that of a risk the insurer would never have accepted? The present article does not answer by inventing a domestic tariff formula. It identifies the need to connect the remedial response with the established significance of the information. That connection would also reduce reliance on an undifferentiated allegation of bad faith.

B. The Strongest Objections to Continuity

An insurer may object that continuing a disputed policy exposes the common premium pool to risks that were never priced. That concern is legitimate where the allegation is supported. The proposed approach preserves the insurer's ability to investigate, explain the consequence sought, and pursue effective resolution. It separates contractual continuity from automatic immediate payment of every disputed claim. A process that cannot protect against deliberate deception would fail to balance the interests it seeks to protect.

A second objection concerns administrative cost. Detailed notices and separate accounts can require additional work. The relevant response is to identify the minimum information necessary for a reviewable decision, not to require an elaborate file for every disagreement.

The original application, a reasoned ground, a payment history, and a clear statement of legal effect are usually central to the insurer's own position. The additional proposal is to make their relationship visible to the party affected.

A policyholder may object that continuing premium obligations are unfair while benefits remain disputed. That objection exposes the need for an agreed or lawfully ordered interim arrangement. An unresolved allegation should not create an unexplained demand for payment. An objection also does not automatically create a right to continuing risk protection without a corresponding contribution. The arrangement must address both sides of the exchange and the consequence of the final outcome.

Another difficulty is the possibility of strategic relabelling. A provider might describe every avoidance dispute as nonpayment after refusing the premium, or as nonrenewal after retrospectively rejecting earlier benefits. The legal effect based classification developed in this article is designed to reveal those inconsistencies. Its effectiveness depends on access to the relevant chronology and records. A classification rule without evidence will not resolve a contested account.

C. The Limits of Generalisation

The proposed framework is most directly relevant to conventional consumer insurance disputes arising from alleged defects in application information. The legal position may differ in compulsory insurance, group schemes, commercial risk policies, or arrangements involving separate statutory duties. Sharia insurance also requires attention to the contractual structure and jurisdictional setting. Extending the argument into those areas calls for analysis beyond a change in terminology.

The article does not establish the prevalence of any disputed practice. Its examples reveal possible legal inconsistencies; they are not a dataset. Research using a defined sample of civil judgments could test how courts distinguish avoidance from claim rejection. Research using lawfully accessible claims records could examine the treatment of premiums while disputes remain open. Those studies could identify whether the proposed notice and accounting safeguards address a frequent problem or a narrower class of difficult cases.

The limited search of IJMRA and related literature also leaves room for additional scholarship. The contribution should be evaluated by the reasoning it offers, its treatment of contrary interests, and the accuracy of its legal distinctions. It does not

depend on asserting that no other author has discussed premiums, continuity, or insurance avoidance. The combination of these issues offers a specific argument that can be challenged and refined.

IX. CONCLUSIONS

The protection against unilateral avoidance becomes practically meaningful when the parties can identify what continues during a dispute and what happens to the money collected under the policy. A disagreement over application information should be distinguished from an ordinary claim rejection, an agreed expiry, a lapse based on established nonpayment, and a decision about renewal. Classification should follow the legal effects asserted. A different label cannot justify obtaining the same consequence without the corresponding legal basis.

The article proposes that the existing agreement remain the reference point for performance while avoidance is contested. This presumption of continuity is an interpretive proposal with defined limits. It neither guarantees every claimed benefit nor creates indefinite insurance. A departure from existing obligations needs an identifiable basis, an explanation of its scope, and a record that can be examined through the applicable process. A policyholder's objection does not automatically excuse premium payment. An insurer's refusal to accept payment must remain visible when it later relies on nonpayment.

Premium restitution requires a separate legal determination. The relevant questions concern the status of the contract, good faith, the risk period, the nature of the receipt, and any statutory exception. The transfer of a refund does not itself establish consent to avoidance. Retention of premiums does not settle every coverage issue. A reasoned financial account should distinguish received and refused payments, benefits already paid, disputed recoveries, and any independently established compensation.

The recommended implementation consists of a specific notice, preservation of application and underwriting material, a documented arrangement for premiums during the dispute, and an express account in any settlement or judgment. These measures connect the restriction on unilateral avoidance with the ordinary demands of contractual performance. Their legal form must match the authority of the institution implementing them. Further legislative consideration could address differentiated remedies for different forms of inaccurate disclosure, supported by evidence about their significance to the original underwriting decision.

An enforceable conclusion to an insurance dispute should leave neither party guessing about the status of the agreement or the treatment of its money. That is the practical standard by which the proposed continuity and restitution framework should be assessed.

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