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## BOOK REVIEW OF DEATH BENEFITS BY J.W. BECTON

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### SUMMARY OF THE BOOK

An insurance company's industrious claims adjuster, Julia Jackson, is tasked with looking into a strange death claim involving Derek Thompson, a man who appeared healthy yet passed away unexpectedly. Julia has concerns after seeing the unusually big claim made by Rebecca Thompson, Derek's wife. Julia's suspicions of foul play are heightened by Rebecca's cool-headedness during their exchanges.

Julia's inquiry reveals several contradictions in Rebecca's account and Derek's medical records. Julia is under pressure from her firm to settle the lawsuit swiftly to avoid unfavourable publicity, but she is determined to find out the truth. Her perseverance leads her to believe Derek's death was staged in order to cash in on the insurance policy.

As Julia investigates deeper, she encounters ethical quandaries and professional risks, balancing her commitment to operate in good faith against the need to defend her company from a potentially fraudulent accusation. Her thorough investigation, adherence to legal standards, and ethical decision-making ultimately revealed the swindle, preventing the insurance claim from being paid improperly.

"Death Benefits" delves into issues of integrity, ethical problems, and the complexity of the insurance industry, emphasizing the value of comprehensive investigations and adherence to legal and moral standards in the face of hardship.

### **FACTUAL SCENARIO**

Julia Jackson, an experienced and careful life insurance claims adjuster, gets a large claim following Derek Thompson's untimely death. Julia begins her research after becoming suspicious of Derek's death due to the hefty reward and odd circumstances. Derek's wife, Rebecca Thompson, the policy's beneficiary,

acts in such a way that Julia questions the genuineness of her mourning. Julia's coworker, Ben North, helps her with the inquiry by offering both professional assistance and a prospective personal interest.

Julia explores further, interviewing Derek's acquaintances, coworkers, and family members to discover anomalies and contradictions in their testimonies. Despite opposition from her company's upper management, who wanted to shut the case fast, Julia persevered. She also faces external threats and harassment from those who wish to keep the truth hidden.

Through her meticulous investigation, Julia discovers that Derek's death may have been part of a planned scheme, gathering critical evidence that points to foul play. Despite numerous challenges, she pieces together the evidence and confronts those involved, ultimately exposing the true motives behind Derek's death. The story concludes with a satisfying resolution, tying together all plot threads and providing closure.

"Death Benefits" focuses on themes of mystery, moral quandaries, business intrigue, and human growth. J.W. Becton's vivid descriptions, tense writing, and well-developed characters have earned him plaudits for penning a captivating and entertaining mystery.

## INSURANCE LAW ISSUES IN "DEATH BENEFITS"

### 1. Fraudulent Claims

**Issue:** The legitimacy of Derek Thompson's life insurance claim is questioned.

**Facts:** Julia Jackson, the claims adjuster, becomes suspicious of the claim owing to the high compensation and the peculiar circumstances surrounding Derek's death. Insurance fraud is defined as tricking the insurer in order to get a benefit that is not earned. Julia's task is to verify the claim's veracity and determine if Derek's death was part of a false attempt to obtain insurance money.

### 2. Beneficiary Conduct

**Issue:** The conduct of Rebecca Thompson, the beneficiary, is scrutinized.

**Facts:** Rebecca's behavior, which appears detached and overly composed for someone grieving a spouse, raises red flags for Julia. In insurance law, a beneficiary's conduct can be a factor in investigating potential fraud. If a beneficiary's actions suggest possible involvement or motive in the death, it can influence the outcome of the claim investigation.

### 3. Duty of Good Faith

**Issue:** The insurance company's obligation to handle the claim with honesty and thoroughness.

**Facts:** Julia confronts internal opposition from her company's upper management, who are keen to settle the claim fast to prevent unfavorable publicity. Insurance firms must operate in good faith and properly evaluate claims before making payments. The urge to settle fast may conflict with this obligation, jeopardizing the claims process's integrity.

### 4. Conflict of Interest

**Issue:** Internal pressures that may conflict with the ethical handling of claims.

**Facts:** The insurance company's goal to conclude the claim fast and minimize negative publicity results in a conflict of interest. This pressure can have an impact on the investigation's thoroughness, since the company's financial interests may outweigh the requirement for a full and unbiased evaluation of the claim.

### 5. Claims Investigation Standards

**Issue:** The procedures and standards required for investigating insurance claims.

**Facts:** Julia's investigation must follow established criteria and processes to provide a fair and accurate evaluation. These criteria include conducting in-depth interviews, carefully obtaining evidence, and maintaining adequate documentation. Proper inquiry is required to ensure that the allegation is evaluated using facts and evidence rather than hurried judgments or internal biases.

### 6. Payout Denial

**Issue:** The legal grounds for denying an insurance claim.

**Facts:** Julia must determine if there is sufficient evidence to deny Rebecca's claim based on potential fraud or other legal reasons. In insurance law, a claim can be denied if the evidence supports that the policyholder's death was not covered under the policy terms or if it is proven that the claim was made under pretenses.

### 7. Regulatory Compliance

**Issue:** Adhering to laws and regulations governing insurance claims.

**Facts:** The insurance company and Julia must guarantee that all activities taken during the inquiry and claims processing are compliant with applicable insurance regulations and legal obligations. This involves following rules governing claims management, fraud prevention, and beneficiary rights. Noncompliance with regulatory criteria might result in legal consequences and jeopardize the integrity of the insurance process.

## APPLICATION OF INSURANCE LAWS AND REGULATIONS

### 1. Fraudulent Claims

**Relevant Section:** Section 45<sup>8</sup> - "Policy not to be called in question after three years"

**Facts:** This section outlines that no policy shall be called into question on the grounds of misstatement after three years from the date of issue of the policy unless fraud is involved. If Julia suspects fraud, the Act allows the insurer to contest the claim if evidence of fraudulent misstatement or concealment is present. Fraudulent claims can be challenged within this time frame.

### 2. Beneficiary Conduct

**Relevant Section:** Section 45 - "Policy not to be called in question after three years"

**Facts:** While Section 45 mainly addresses issues related to misstatements, the conduct of the beneficiary can influence the investigation process. If the beneficiary's behavior suggests potential involvement in fraudulent activities, the insurer has the right to investigate further. The Act supports thorough investigations if fraud is suspected.

### 3. Duty of Good Faith

**Relevant Section:** Section 19<sup>9</sup> - "Duty of disclosure"

**Facts:** The Act requires parties to an insurance contract to disclose all material facts honestly. This duty of disclosure is crucial for maintaining good faith in the insurance relationship. If internal pressures compromise this duty, it can lead to legal challenges. Insurers must act in good faith by thoroughly investigating claims and not settling hastily.

### 4. Conflict of Interest

**Relevant Section:** Section 49<sup>10</sup> - "Power of insurer to refuse or reduce claims"

**Facts:** This section empowers insurers to refuse or reduce claims if they suspect fraud or misrepresentation. However, internal conflicts of interest, such as pressure to settle quickly, can conflict with the insurer's obligation to uphold the Act's provisions. Ensuring unbiased handling of claims is essential to avoid conflicts of interest affecting the outcome.

### 5. Claims Investigation Standards

**Relevant Section:** Section 45 - "Policy not to be called in question after three years"

**Facts:** Proper investigation of claims is a requirement under the Act. Insurers must adhere to standards that ensure fair assessment and due process. This involves conducting comprehensive investigations and maintaining accurate records, as any lapse in standards can lead to disputes and legal issues.

<sup>8</sup> The Insurance Act, 1938, S. 45, No. 4, Acts of Parliament, 1938 (India).

<sup>9</sup> The Insurance Act, 1938, S. 19, No. 4, Acts of Parliament, 1938 (India).

<sup>10</sup> The Insurance Act, 1938, S. 49, No. 4, Acts of Parliament, 1938 (India).

## 6. Payout Denial

**Relevant Section:** Section 45 - "Policy not to be called in question after three years"

**Facts:** Insurers can deny claims based on fraud or misrepresentation discovered within three years. If Julia finds evidence of fraud, Section 45 provides the legal grounds for denying the payout. This ensures that insurance funds are not misused and that claims are only paid out when justified.

## 7. Regulatory Compliance

**Relevant Sections:** Sections 3-4 - "Regulation and control of insurance business"

**Facts:** These sections regulate the conduct of the insurance business, ensuring compliance with legal standards and protecting policyholders' rights. The insurer must follow regulations regarding claims handling, fraud prevention, and overall business practices. Compliance with these regulations is crucial for maintaining the legality and integrity of the insurance operations.

## ARGUMENTS & RESOLUTIONS

### 1. Fraudulent Claims

#### Argument:

- Enhanced Evidence Collection: Advocate for the use of modern forensic technologies and investigation tactics to collect and preserve evidence of fraud. Emphasize the significance of digital evidence, such as transaction records and communication logs, in supporting charges of fraudulent conduct.
- Legal Precedents and Judicial Interpretation: Cite pertinent legal cases in which courts addressed

false claims under Section 45 of the Insurance Act of 1938. Highlight how these examples support a rigorous approach to fraud detection and the use of Section 45.

#### Resolution:

- Judicial Remedies: Advocate for legal action if there is significant evidence of fraud. Use provisions of the Insurance Act to dispute fraudulent claims in court and obtain appropriate remedies.
- Legislative Recommendations: Propose revisions to the Insurance Act that contain clearer standards for dealing with fraud situations, such as longer investigation periods or required reporting procedures.

### 2. Beneficiary Conduct

#### Argument:

- Behavioral Evidence in Court: Argue for the inclusion of behavioral evidence, supported by psychological assessments and expert testimony, to evaluate the credibility of a beneficiary's conduct. This can provide a more comprehensive view of potential involvement in fraudulent activities.
- Precedents on Beneficiary Conduct: Reference case law where courts have considered beneficiary conduct in the context of claim disputes, demonstrating how such conduct can impact claim decisions.

#### Resolution:

- Due Process in Investigations: Ensure that investigations into beneficiary conduct adhere to principles of due process and fairness. Advocate for standardized procedures to assess and address beneficiary behavior without bias.

- Legal Safeguards: Recommend implementing legal safeguards to protect beneficiaries from wrongful allegations and ensure that their conduct is evaluated based on solid evidence.

### 3. Duty of Good Faith

#### Argument:

- Duty of Disclosure Enforcement: Stress the importance of enforcing the duty of disclosure under Section 19 of the Insurance Act. Advocate for stronger penalties for non-compliance and more rigorous audits to ensure transparency in policyholder disclosures.
- Judicial Oversight: Propose that courts take an active role in overseeing and enforcing the duty of good faith, ensuring that insurers and policyholders adhere to ethical standards.

#### Resolution:

- Enhanced Compliance Mechanisms: Develop and implement compliance mechanisms within insurance companies to ensure adherence to the duty of good faith. This includes regular training for employees on ethical practices and disclosure requirements.
- Legal Recourse for Breach: Advocate for clear legal recourse for breaches of the duty of good faith, including remedies and compensation for parties affected by non-disclosure or misrepresentation.

### 4. Conflict of Interest

#### Argument:

- Conflict Management Policies: Argue for the adoption of

comprehensive conflict of interest management policies within insurance companies. These policies should include mechanisms for identifying, disclosing, and addressing conflicts of interest.

- Judicial Remedies for Conflict: Utilize case law to demonstrate how courts have addressed conflicts of interest in insurance claims, advocating for judicial remedies when internal conflicts affect the fairness of claim handling.

#### Resolution:

- Independent Review Bodies: Propose the establishment of independent review bodies or ombudsmen to oversee and address conflicts of interest in insurance companies, ensuring impartiality in claims processing.
- Internal Controls: Strengthen internal controls and compliance frameworks to prevent conflicts of interest from influencing claims decisions.

### 5. Claims Investigation Standards

#### Argument:

- Technological Integration: Advocate for the integration of technological tools, such as digital claims management systems and forensic analytics, to enhance the efficiency and accuracy of claims investigations.
- Legal Framework for Standards: Support the development of a legal framework that sets clear standards for claims investigations, ensuring consistency and fairness across the industry.

#### Resolution:

- Regulatory Guidelines: Recommend that regulators issue detailed guidelines for claims investigations, outlining best practices and procedural standards to be followed by insurers.
- Training and Certification: Propose mandatory training and certification for claims adjusters and investigators to ensure they are well-versed in the latest investigative techniques and legal requirements.

### 6. Payout Denial

#### Argument:

- Automated Decision-Making: Advocate for the use of automated decision-making systems to assist in evaluating the validity of claims and providing consistent grounds for payout denials.
- Transparency in Denial Reasons: Emphasize the need for transparency in the reasons for denying claims, ensuring that policyholders receive clear and detailed explanations.

#### Resolution:

- Appeal and Review Processes: Establish robust appeal and review processes for denied claims, allowing policyholders to challenge denial decisions and seek independent reviews.
- Clear Denial Criteria: Develop and enforce clear criteria for denying claims, ensuring that decisions are based on well-defined legal and factual grounds.

### 7. Regulatory Compliance

#### Argument:

- Reg-Tech Solutions: Advocate for the adoption of Reg-Tech solutions to streamline compliance monitoring and reporting, making it easier for insurers to adhere to regulatory requirements.
- Dynamic Compliance Framework: Encourage the creation of a dynamic compliance system that can react quickly to changes in legislation and industry standards.

#### Resolution:

- Regulatory Partnerships: Encourage collaboration between insurers and regulators to ensure that compliance processes are regularly updated and matched with changing regulatory requirements.
- Continuous Improvement: Promote a culture of continuous development inside insurance firms, with an emphasis on frequent reviews and modifications to compliance policies to guarantee continued legal compliance.

### CONCLUSION

Analyzing J.W. Becton's "Death Benefits" demonstrates a complicated interaction of ethical and legal issues in the insurance sector. The story revolves around the heroine, Julia Jackson, who works as a claim adjuster and is at the center of a potentially fraudulent death claim. Throughout her inquiry, Julia must balance her desire to quickly settle the claim with her determination to discover the truth.

The case raises several important concerns, including the identification of false claims, beneficiary behavior, the duty of good faith, conflicts of interest within the insurance firm, claims investigation standards, payout denials, and regulatory compliance. Each of these categories emphasizes important aspects of

insurance law and the roles of insurance professionals.

Julia's dedication and ethical approach demonstrate the significance of conducting comprehensive and fair investigations. Her focus on legal concepts, such as those established in the Insurance Act of 1938, emphasizes the need to adhere to regulatory standards in order to safeguard the integrity of the claims process. Furthermore, her ability to overcome internal conflicts of interest while prioritizing her duty of good faith serves as a model for dealing with similar issues in the sector.

The case's settlement, which prevented a wrongful payout due to fraud, emphasizes the need for effective fraud detection systems and transparent claims processes. Insurance firms may better protect themselves and their clients against fraudulent activity by using modern investigative tools and adhering to a strict ethical code.

In conclusion, "Death Benefits" not only offers a gripping narrative but also gives useful insights into the complexities of insurance law and the ethical duties of those who work in the industry. The tale emphasizes the essential balance between adhering to legal requirements and resolving the actual obstacles that insurance professionals encounter in their quest for justice and fairness.



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