# California Insurance Exam

## Practice Questions & Answers

1,086 original practice questions with full explanations - 90 written on California insurance law, each citing the statute or rule it tests, plus the 996 national questions that appear on every state's exams.

### Contents



### California exam facts

Life Insurance: 75 questions (Life-Only Agent; pretest split not published). Time: 90 minutes. Passing: 60%. Fee: $55. Vendor: PSI. Prelicensing: 20-hour per-line prelicensing repealed effective Jan 1, 2026 (AB 943); 12 hours of Ethics & California Insurance Code study still required before license issuance

Health Insurance: 75 questions (Accident & Health or Sickness Agent; pretest split not published). Time: 90 minutes. Passing: 60%. Fee: $55. Vendor: PSI. Prelicensing: 20-hour per-line prelicensing repealed effective Jan 1, 2026 (AB 943); 12 hours of Ethics & California Insurance Code study still required before license issuance

Property & Casualty Insurance: 150 questions combined Property & Casualty Broker-Agent (separate Property 75 q and Casualty 75 q exams also listed, 90 min each). Time: 180 minutes. Passing: 60%. Fee: $55. Vendor: PSI. Prelicensing: 20-hour per-line prelicensing repealed effective Jan 1, 2026 (AB 943); 12 hours of Ethics & California Insurance Code study still required before license issuance

Verified July 2026 from CDI - Examinations: Time Limit and Number of Questions (+ CDI fee schedule and AB 943 notice): https://www.insurance.ca.gov/0200-industry/0010-producer-online-services/0200-exam-info/ExamTimesandQuestion.cfm

**https://insuranceexampractice.com**

# California law - Life Insurance (30 questions)

**1. A person in California sells and negotiates life insurance without holding a valid license. What is the maximum criminal penalty for that misdemeanor?**

A. A fine of up to $5,000
B. A fine of up to $50,000, up to one year in county jail, or both
C. A fine of up to $10,000 and a permanent bar from licensure
D. A fine of up to $100,000 and up to three years in state prison

**2. A 45-year-old Californian buys an individual life policy. The policy's free-look notice must give the owner how long to return it for a full refund?**

A. Exactly 10 days
B. At least 20 days
C. A period the insurer sets that is not less than 10 days nor more than 30 days
D. At least 30 days

**3. Under California's senior-citizen free-look rule for life insurance and annuities, who qualifies as a senior citizen and what is the minimum return period?**

A. Age 60 or older on the date of purchase; not less than 30 days
B. Age 65 or older on the date of purchase; not less than 30 days
C. Age 60 or older on the date of purchase; not less than 10 days
D. Age 62 or older on the date of purchase; not less than 20 days

**4. A California individual life policy issued today must give the owner what minimum grace period after a premium due date, and how far ahead of a lapse for nonpayment must the insurer mail notice?**

A. 30-day grace period; notice 10 days before termination
B. 31-day grace period; notice 15 days before termination
C. 60-day grace period; notice 15 days before termination
D. 60-day grace period; notice at least 30 days before termination

**5. Before an individual life policy may be issued in California, what right must the applicant be given regarding lapse notices?**

A. The right to have the insurer waive the first missed premium
B. The right to designate at least one additional person to receive notice of lapse or termination
C. The right to a 90-day extension of the grace period on request
D. The right to name a trustee to pay overdue premiums

**6. A California life agent is taking an application that will replace an existing life policy. By when must the agent present the Notice Regarding Replacement?**

A. Within 10 days after the application is signed
B. At policy delivery
C. Not later than at the time of taking the application
D. Only when the existing insurer asks for it

**7. Under California's replacement article, within what time after receiving a replacement application must the replacing insurer send written notice to each existing life insurer, and how long does the owner of the new policy have to obtain an unconditional refund?**

A. Three working days; 30 days from delivery of the new policy
B. Five working days; 10 days from delivery
C. 10 working days; 20 days from delivery
D. 30 days; 60 days from delivery

**8. A California life agent wants to begin selling annuities to individual consumers. How much annuity-specific training does the Insurance Code require initially and at each renewal?**

A. Four hours initially and four hours at each renewal
B. Eight hours initially and eight hours at each renewal
C. Twelve hours initially and none afterward

D. Eight hours before soliciting and four hours before each license renewal

**9. A California agent arranges to meet a prospect age 65 or older at the prospect's home. When must the written meeting notice be delivered?**

A. At the start of the meeting
B. No less than 24 hours and no more than 14 days before the initial in-home meeting
C. At least seven days before the meeting
D. No notice is required if the senior initiated the contact

**10. If a California life insurer becomes insolvent, the California Life and Health Insurance Guarantee Association covers life insurance death benefits up to what amount for any one life?**

A. $100,000
B. $250,000
C. $300,000, but not more than $100,000 in net cash surrender and withdrawal values
D. $500,000

**11. An employee covered by a California group life policy leaves the employer. Within how many days after termination may the employee apply for an individual policy without evidence of insurability?**

A. 31 days
B. 15 days
C. 60 days
D. 90 days

**12. For how long must a California life insurer and its agents keep the application and related records for each life policy sold in the state?**

A. Two years after the policy is issued
B. Three years after the application date
C. Seven years after delivery
D. At least five years after actual delivery of the policy, or five years after the application date if no policy was issued

**13. A California life insurer mails a policy by ordinary first-class mail with no signed receipt. Under the policy-delivery statute, when is the policy deemed received?**

A. Three days after mailing
B. Six months after the date of issuance, provided premiums have been paid
C. On the date the first premium is paid
D. Never, unless the owner signs a receipt

**14. A California license applicant has a spotty employment history, and the Commissioner concludes the applicant is not of good business reputation and is lacking in integrity. What may the Commissioner do?**

A. Issue the license but require a surety bond
B. Deny the license application on those grounds
C. Issue a restricted license valid for one year
D. Nothing, because only criminal convictions justify denial

**15. Three years ago, another state denied an applicant's real estate license for cause. The applicant now applies for a California life agent license. How does the prior denial affect the application?**

A. It has no effect because it involved a different profession
B. It automatically bars licensure for ten years
C. The Commissioner may deny the license because a professional license application was denied for cause within five years
D. It requires only that the applicant retake the examination

**16. An insurer signs a notice of appointment for a newly contracted California life agent and files it with the Commissioner. When does the agent's authority to transact for that insurer become effective?**

A. As of the date the notice of appointment is signed
B. Thirty days after the Commissioner receives the notice
C. On the first day of the month following filing
D. Only after the agent writes the first application

**17. A California agent collects premium from a client but uses the money to cover personal expenses before remitting it. Under the Insurance Code, this conduct is treated as what?**

A. A civil rate violation only
B. Commingling, punishable by license restriction only
C. An unfair trade practice subject only to a cease and desist order
D. Theft, because premium funds are held in a fiduciary capacity

**18. A California agency holds collected premiums for several days before remitting them to insurers. If it does not remit them immediately, how must those fiduciary funds be kept?**

A. In the agency's general operating account with careful bookkeeping
B. At all times in a separate trust account in an FDIC-insured financial institution
C. In any interest-bearing account titled in the owner's name
D. In cash in the agency's office safe

**19. To win a sale, a California agent shows a policyholder a misleading comparison of two insurers designed to get her to surrender her existing whole life policy and buy his product. This practice is prohibited as what?**

A. Twisting - a misleading representation or comparison made to induce lapse or surrender
B. Rebating
C. Defamation of an insurer
D. Coercion

**20. Before a California life agent license may be ISSUED, the applicant must complete a required course of study of how many hours? (Completing it is not required to schedule or take the exam.)**

A. 6 hours, including 2 hours on annuities
B. 25 hours, including 3 hours of ethics
C. 12 hours, including one hour of study on insurance fraud
D. 40 hours, with no specific fraud component

**21. A California agent designs her own flyer advertising an insurer's life product to prospects age 65 and older. Before she may use the flyer, what does the Insurance Code require?**

A. Filing with the National Association of Insurance Commissioners
B. A 30-day waiting period after mailing a copy to each prospect
C. Approval by the agent's errors and omissions carrier
D. The insurer's written approval of the advertisement

**22. A producer recommends that a 68-year-old Californian replace an existing annuity on which she would pay a surrender charge. Under California's senior-replacement rule, the sale is prohibited unless the replacement does what?**

A. Confers a substantial financial benefit and gives the consumer a tangible net benefit
B. Pays the producer a lower commission than the original sale
C. Extends the surrender period by at least two years
D. Is approved in advance by the Commissioner

**23. A California life policy that carries a surrender charge must alert the buyer with a special notice. Where and how must that notice appear?**

A. In 8-point type anywhere within the policy provisions
B. In bold 12-point type on the front of the policy jacket or the cover page
C. Only in the agent's oral sales presentation
D. In a separate letter mailed 60 days after delivery

**24. A California business buys life insurance on a key employee who later quits. When the former employee dies years afterward, the insurer questions insurable interest. When must insurable interest have existed?**

A. Both when the policy was issued and at the time of death
B. Only at the time of death
C. At the time the contract became effective; it need not exist at the time of loss
D. Continuously for the life of the contract

**25. A California individual life policy has been in force for three years during the insured's lifetime. On which basis may the insurer still contest it?**

A. Any material misstatement in the application
B. Nonpayment of premiums
C. Misstatements about tobacco use only
D. It may not contest the policy for any reason

**26. A beneficiary's claim on a California life policy is complete, but the insurer takes 90 days after the insured's death to pay. What does the insurer owe beyond the death benefit?**

A. Interest accruing from the date of the insured's death
B. Nothing, if payment was made within six months
C. A flat statutory penalty of $500
D. Interest accruing only from the date proof of death was filed

**27. A California policyowner signs a life settlement contract, receives all disclosures, and later receives the settlement proceeds. How long does the owner have to rescind the contract?**

A. 10 days from execution, with no other option
B. 60 days from execution in all cases
C. 90 days, but only if the insured dies
D. 30 days from execution or 15 days from receipt of the proceeds, whichever is sooner

**28. During a claim, a California insurer discovers an innocent inaccuracy in the insured's application, which was attached to the life policy. Absent fraud, how are the insured's statements treated?**

A. As warranties that void the policy if untrue
B. As representations, not warranties
C. As binding admissions against the beneficiary
D. As having no legal effect whatsoever

**29. When a California agent solicits a life insurance prospect who is 65 years of age or older, what special statutory duty applies to the transaction?**

A. A duty of honesty, good faith, and fair dealing
B. A duty to obtain a physician's certification of capacity
C. A duty to record all conversations
D. A duty to co-sign the application with a family member

**30. A California life insurer wants an applicant to undergo an HIV test as part of underwriting. What must the insurer obtain first?**

A. A court order authorizing the test
B. Verbal permission noted in the agent's file
C. The applicant's written informed consent for the test
D. Approval from the applicant's primary physician

# California law - Health Insurance (30 questions)

**31. A California individual disability (accident and health) policy with premiums payable monthly must provide a grace period of at least how many days?**

A. 7 days
B. 31 days
C. 10 days
D. 60 days

**32. Under California's required disability policy provisions, written notice of claim must be given to the insurer within how many days after a covered loss begins?**

A. 10 days
B. 20 days, or as soon thereafter as is reasonably possible
C. 30 days
D. 90 days

**33. A California disability policy requires written proof of loss. What is the standard deadline, and what is the absolute outside limit if proof could not reasonably be given in time?**

A. 30 days; six months
B. 60 days; one year
C. 90 days; two years
D. 90 days after the loss (or after the end of the period of liability for periodic payments); no later than one year unless the claimant lacks legal capacity

**34. After receiving notice of claim under a California disability policy, the insurer fails to send claim forms. After how many days may the claimant simply submit written proof of the occurrence, character and extent of the loss instead?**

A. 15 days
B. 10 days
C. 20 days
D. 30 days

**35. Under California's time-limit-on-certain-defenses provision, after a disability policy has been in force for how long during the insured's lifetime does it become incontestable as to statements in the application?**

A. One year
B. Two years (excluding any period the insured is disabled)
C. Three years
D. Five years

**36. A California insurer sells a disability policy to a 70-year-old. What examination (free-look) period must the policy provide, and how quickly must premiums be refunded if it is returned?**

A. 10 days; refund within 10 days
B. 20 days; refund within 45 days
C. 30 days after receipt; refund within 30 days after the insurer receives the returned policy
D. 60 days; refund within 60 days

**37. How long is the initial Medicare supplement open enrollment period in California, and when does it begin?**

A. Six months, beginning the first day of the first month in which the person is both 65 or older and enrolled in Medicare Part B
B. Three months, beginning on the person's 65th birthday
C. Sixty days, beginning when Part A coverage starts
D. Twelve months, beginning at retirement

**38. A California insurer pays a producer for a Medicare supplement sale. What limit does the Insurance Code place on first-year compensation, and for how many renewal years must renewal compensation continue?**

A. First-year commission may not exceed the renewal commission; three renewal years

B. First-year commission may not exceed 150 percent of second-year; four renewal years

C. No limit on first-year commission; two renewal years

D. First-year commission may not exceed 200 percent of the second-year commission; the same renewal amount must be paid for no fewer than five renewal years

**39. A Californian's employer-sponsored retiree health plan that supplemented Medicare is terminated. Under the Medicare supplement guaranteed-issue rules, within how many days of losing that coverage must the person apply to be guaranteed a policy?**

A. 30 days

B. 63 days

C. 90 days

D. 180 days

**40. A newly licensed California accident and health agent wants to sell long-term care insurance. What LTC training does the Insurance Code require?**

A. Four hours once, before the first sale

B. Sixteen hours every license term

C. Eight hours in each of the first four 12-month periods after licensing, then eight hours before each license renewal

D. Twelve hours initially and four hours every two years

**41. How many hours of continuing education must a California accident and health or sickness agent complete before each license renewal, and how many of them must be in ethics?**

A. 24 hours, including three hours of ethics

B. 20 hours, including two hours of ethics

C. 30 hours, including four hours of ethics

D. 48 hours if also licensed for property and casualty

**42. A California licensee is convicted of a misdemeanor after the license is issued. Within how many days of learning of that change in background information must the licensee notify the Commissioner in writing?**

A. 10 days

B. 15 days

C. 60 days

D. 30 days

**43. A California disability insured says her agent verbally promised broader coverage than the policy shows. Under the required entire-contract provision, what is the status of the agent's promise?**

A. It binds the insurer because the agent is its representative

B. It is void; no change is valid until approved by an insurer executive officer, and agents cannot alter or waive policy terms

C. It binds the insurer if made in front of a witness

D. It converts the policy into a group contract

**44. A lapsed California disability policy is reinstated on June 1. On June 6 the insured falls ill; on June 20 he is hurt in an accident. What does the reinstated policy cover?**

A. Both the sickness and the injury

B. The sickness only

C. The injury, but not the sickness, because sickness must begin more than 10 days after reinstatement

D. Neither loss until 60 days have passed

**45. A California disability income policy pays monthly benefits during a long disability. Under the required time-of-payment provision, how frequently at minimum must accrued periodic indemnities be paid?**

A. Not less frequently than monthly
B. Weekly
C. Quarterly
D. Only in a lump sum when disability ends

**46. A California accident policy insured dies with no effective beneficiary designation. Under the required payment-of-claims provision, to whom is the loss-of-life indemnity paid?**

A. The state unclaimed property fund
B. The insured's employer
C. The hospital that provided final care
D. The estate of the insured

**47. While a large disability claim is pending, a California insurer wants its own physician to examine the claimant a second time. What right does the required policy provision give the insurer?**

A. One examination per claim, at the claimant's expense
B. To examine the insured as often as reasonably required during the claim, at the insurer's own expense, and to make an autopsy where not forbidden by law
C. Examinations only with a court order
D. No examination rights after proof of loss is filed

**48. A California disability claimant submits written proof of loss and is denied. Under the required legal-actions provision, when may she sue, and what is the deadline?**

A. Immediately, but within one year of the loss
B. After 30 days, but within five years of denial
C. No sooner than 60 days after furnishing proof of loss, and no later than three years after proof was required
D. Any time within ten years of the loss

**49. A California disability policy insured wants to name a new beneficiary. Her ex-spouse, the current revocable beneficiary, objects. What does the required change-of-beneficiary provision say?**

A. The change requires the current beneficiary's written consent
B. Beneficiaries may only be changed on policy anniversary dates
C. The insurer may refuse any change after a claim has been filed
D. The right to change is reserved to the insured; the beneficiary's consent is not required unless the designation was irrevocable

**50. A covered Californian gives birth. When does the family's health policy begin covering the newborn, and may the insurer limit that coverage?**

A. From the moment of birth, and the insurer may not disclaim or limit it
B. After 31 days, once the child is formally enrolled
C. From the first premium paid for the child
D. Only if maternity coverage was purchased as a rider

**51. A California health insurer receives a complete, uncontested claim but pays it 45 days later. What deadline did it miss, and what does late payment cost?**

A. 15 calendar days; a $100 flat penalty
B. 30 calendar days; interest accrues at 15 percent per annum starting the day after the deadline
C. 60 working days; interest at 7 percent
D. 90 calendar days; no monetary consequence

**52. A Californian receives a newly delivered long-term care policy and has second thoughts. What return right must the policy provide?**

A. 10 days to return it for a 75 percent refund
B. No return right once the application is signed
C. 30 days from delivery to return it by first-class mail for a full refund of all premiums and any policy fee
D. 60 days, but only if care has not yet been needed

**53. A California LTC policyholder with worsening dementia lets her premium go unpaid and the policy terminates. What protections did the Insurance Code build in for this situation?**

A. None; LTC policies lapse like any other coverage

B. Only a 7-day telephone warning before lapse

C. A mandatory premium waiver after age 80

D. A designated third person receives lapse notice mailed at least 30 days after the premium is due and unpaid, and the policy may be reinstated within five months on proof of cognitive impairment or loss of functional capacity

**54. A California agent presents a long-term care policy quote. What inflation-protection offer must the insurer have made available with the policy?**

A. An option that compounds benefit levels annually at not less than 5 percent

B. A simple-interest increase of 2 percent per year

C. A one-time benefit increase at age 75

D. Inflation protection is optional for insurers to offer

**55. A Californian with asthma buys a new nongrandfathered individual health benefit plan. What may the insurer impose regarding her preexisting condition?**

A. A 6-month exclusion period

B. A 12-month waivered-condition rider

C. Nothing; preexisting condition provisions, waivered condition provisions, and waiting periods are all prohibited

D. A premium surcharge in place of an exclusion

**56. A California insurer is found to have violated the senior insurance article for the first time in marketing a policy to a 70-year-old. What administrative penalty applies to the insurer?**

A. $500

B. $10,000, with $30,000 to $300,000 for subsequent or knowing violations

C. $1,000, the same as for an individual agent

D. License revocation is the only available remedy

**57. A California insurer files a new disability policy form whose benefit wording is ambiguous and whose benefits offer little real value. What must the Commissioner do?**

A. Approve it if the premium is low enough

B. Approve it with a warning label

C. Send it to the NAIC for review

D. Withhold approval, because forms that are ambiguous or likely to mislead, or whose benefits are not of real economic value to the insured, may not be approved

**58. Apart from nonpayment of premium, on which of the following grounds may a California individual health insurance policy be canceled or rescinded?**

A. Fraud or intentional misrepresentation of material fact

B. The insured files too many claims

C. The insured develops a costly chronic illness

D. The insured turns 65

**59. A Californian receives his new Medicare supplement policy, reads it, and decides he does not want it. What right of return does California law give him?**

A. 15 days, with a prorated refund

B. No return right for Medicare supplement products

C. 30 days from receipt to return it for a full premium refund for any reason, voiding the contract from inception

D. 90 days, but only for duplicate coverage

**60. An employee of a small California firm loses group health coverage after a qualifying event and elects Cal-COBRA continuation. For how long may the continuation coverage last?**

A. 6 months

B. Until the date 36 months after the coverage would otherwise have terminated

C. 18 months, with no extensions ever available

D. Indefinitely, as long as premiums are paid

# California law - Property & Casualty Insurance (30 questions)

**61. What are the minimum automobile liability limits required under California's financial responsibility law for a policy in force in 2026?**

A. $15,000 per person / $30,000 per accident / $5,000 property damage
B. $30,000 per person / $60,000 per accident / $15,000 property damage
C. $25,000 per person / $50,000 per accident / $25,000 property damage
D. $50,000 per person / $100,000 per accident / $25,000 property damage

**62. A California driver qualifies for a Good Driver Discount policy. The rate must be at least how much below the rate the driver would otherwise be charged?**

A. 10 percent
B. 15 percent
C. 20 percent
D. 25 percent

**63. To qualify as a good driver in California, an applicant must have been licensed for how long and may have accumulated no more than how many violation points during that time?**

A. Licensed for the previous three years with not more than one violation point
B. Licensed for the previous five years with no violation points
C. Licensed for the previous two years with not more than two violation points
D. Licensed for the previous three years with not more than three violation points

**64. A California insurer cancels a private passenger auto policy mid-term for a reason other than nonpayment. How many days' notice must it mail or deliver before the cancellation takes effect?**

A. 10 days
B. 15 days
C. 30 days
D. 20 days

**65. A California auto insurer decides not to renew a policy. How far before expiration must the written notice of nonrenewal be delivered or mailed?**

A. At least 20 days
B. At least 30 days
C. At least 45 days
D. At least 75 days

**66. Which of the following is NOT one of the grounds on which a California insurer may cancel an automobile policy during the policy period?**

A. Nonpayment of premium
B. Suspension of the named insured's driver's license during the policy period or the preceding 180 days
C. The insured filed a single not-at-fault claim
D. Discovery of fraud by the named insured in pursuing a claim under the policy

**67. A California insurer intends not to renew a homeowners (residential property) policy that expires next year. How far before expiration must the notice of nonrenewal be mailed or delivered?**

A. 20 days
B. 30 days
C. 45 days
D. 75 days

**68. A California residential property policy has been in effect for more than 60 days. On which of the following grounds may the insurer still cancel it?**

A. Physical changes in the property that make it uninsurable
B. The insured filed a claim for a covered loss
C. The insured's credit score dropped
D. The insurer decided to leave the residential market

**69. A California insurer will not renew a commercial property policy. Within what window before the end of the policy period must the nonrenewal notice be given?**

A. At least 30 days
B. At least 60 days but not more than 120 days
C. At least 45 days but not more than 90 days
D. At least 75 days

**70. The Governor declares a state of emergency for a wildfire. What premium grace period must a California insurer offer on residential property policies covering homes in the affected area?**

A. 30 days
B. 45 days
C. A 60-day grace period, for a period of 60 days after the emergency
D. 90 days

**71. A California auto insurer must offer uninsured motorist bodily injury coverage with every liability policy. Up to what limits is the insurer required to offer it?**

A. $15,000 per person / $30,000 per accident
B. $100,000 per person / $300,000 per accident
C. Limits equal to the insured's liability limits, whatever they are
D. $30,000 per person / $60,000 per accident, though higher limits may be offered up to the liability limits

**72. A California property-casualty insurer is declared insolvent. What is the maximum the California Insurance Guarantee Association (CIGA) will pay on a covered claim other than workers' compensation?**

A. $500,000 per claim, less claims of $100 or less
B. $300,000 per claim
C. $1,000,000 per claim
D. The full policy limit with no cap

**73. An employee knowingly files a false workers' compensation claim in California. What is the maximum fine for that offense?**

A. $10,000
B. $150,000 or double the value of the fraud, whichever is greater
C. $50,000
D. $100,000

**74. Under California's Fair Claims Settlement Practices Regulations, after receiving proof of claim an insurer must accept or deny the claim within how many calendar days, and once it accepts a claim, within how many days must it tender payment?**

A. 15 days; 15 days
B. 30 days; 30 days
C. 40 days to accept or deny; 30 days to pay after acceptance
D. 60 days; 45 days

**75. A claimant writes to a California insurer about a pending claim in a way that clearly expects a reply. Under the fair claims regulations, how quickly must the insurer respond?**

A. Immediately, but no more than 15 calendar days after receipt
B. Within 10 business days
C. Within 30 calendar days
D. Within 40 calendar days

**76. The Commissioner finds that a California licensee committed an unfair act under the Unfair Practices Act. What civil penalty may be imposed for each act?**

A. Up to $1,000, or $2,500 if willful
B. Up to $2,500, or $5,000 if willful
C. Up to $25,000 per act regardless of intent
D. Up to $5,000 per act, or up to $10,000 per act if the act was willful

**77. How many hours of continuing education must a California property and casualty broker-agent complete before each license renewal, and what must be included?**

A. 20 hours, with two hours of ethics

B. 24 hours, including three hours of ethics (which now includes one hour on insurance fraud)

C. 30 hours, including four hours of ethics

D. 12 hours of ethics and California Insurance Code

**78. A California broker-agent prints business cards and written price quotations without the license number. What is the penalty for a second offense?**

A. $200

B. $1,000

C. $500

D. License suspension for 30 days

**79. A California personal auto insurer wants to start using new, higher rates it has developed. Under Proposition 103, what must happen before the rates may be used?**

A. The rates must be approved by the Commissioner prior to their use

B. The rates must simply be filed 30 days before use

C. Nothing; California is a use-and-file state

D. A majority of policyholders must consent

**80. A consumer group makes a timely request for a hearing on a California personal lines rate filing. At what proposed increase does a hearing become mandatory?**

A. Any increase over 25 percent

B. Hearings are always discretionary with the Commissioner

C. More than 7 percent for personal lines (15 percent for commercial lines)

D. More than 3 percent for all lines

**81. A California insurer issues a new homeowners policy but never mentions earthquake coverage. What legal requirement did it violate?**

A. None; earthquake coverage is purely optional to offer

B. No residential property policy may be issued or delivered unless the named insured is offered earthquake coverage

C. Earthquake coverage must be automatically included in every policy

D. Earthquake coverage may only be sold by the state

**82. Which statement best describes the California Earthquake Authority (CEA)?**

A. A federal agency funded by congressional appropriations

B. A private mutual insurer owned by its policyholders

C. A reinsurer that sells no policies to consumers

D. A publicly administered entity, governed by a board under the Commissioner's authority, that sells basic residential earthquake insurance funded by premiums

**83. A new California business hires its first employee. How may the employer lawfully secure payment of workers' compensation?**

A. By posting a cash bond with the county clerk

B. By buying health insurance for the employee

C. By insuring with an authorized workers' compensation insurer, or obtaining a certificate of consent to self-insure from the Director of Industrial Relations

D. By having the employee sign a liability waiver

**84. A California driver rear-ends another car, causing $1,500 in damage to the other vehicle but no injuries. What must the driver do under the financial responsibility law?**

A. Report the accident to the DMV within 10 days, because damage to one person's property exceeded $1,000

B. Nothing, because no one was hurt

C. Report only to the local police within 24 hours

D. Report to the DMV within 30 days regardless of damage

**85. An income-eligible California driver qualifies for the state's low-cost automobile insurance program. What liability limits does that policy provide?**

A. $30,000 / $60,000 / $15,000

B. $10,000 per person / $20,000 per accident for bodily injury or death / $3,000 property damage

C. $15,000 / $30,000 / $5,000

D. $25,000 / $50,000 / $10,000

**86. A California homeowner's fire claim is denied and she considers suing. Under the standard form fire policy, how long after inception of the loss does she ordinarily have to file suit?**

A. Six months

B. Five years

C. 12 months (24 months when the loss relates to a declared state of emergency)

D. There is no time limit if proof of loss was filed

**87. A California insurer cancels a commercial property policy mid-term because the insured stopped paying premium. How much advance written notice of cancellation is required?**

A. At least 60 days in all cases

B. At least 45 days

C. Five days

D. No less than 10 days, versus at least 30 days for other permitted cancellation grounds

**88. A homeowner in a wildfire-prone California area cannot find coverage in the voluntary market and applies to the FAIR Plan. What does the FAIR Plan's "basic property insurance" include?**

A. Standard fire policy perils plus extended coverage and vandalism and malicious mischief, at a fixed location

B. Full homeowners coverage including personal liability

C. Automobile physical damage coverage

D. Flood and earthquake coverage

**89. Liability on a California auto claim is reasonably clear, yet the adjuster stalls and makes no settlement offer. Under the Unfair Practices Act's list of 16 unfair claims settlement practices, this conduct is best described as what?**

A. Permissible negotiation strategy

B. Rebating

C. Not attempting in good faith to effectuate a prompt, fair, and equitable settlement of a claim in which liability has become reasonably clear

D. Churning

**90. A California body shop pays a claims adjuster a fee for steering auto damage claimants to the shop. Under the Insurance Code, what is the consequence of this referral arrangement?**

A. It is lawful if disclosed to the insurer

B. It is only a civil infraction with a $250 fine

C. It violates federal law but not California law

D. It is a crime; a first conviction can bring up to one year in county jail and/or a fine of up to $50,000

# National - Life Insurance (306 questions)

**91. What is the primary purpose of life insurance?**

A. To provide financial protection to beneficiaries upon the insured's death
B. To reimburse the insured for damage to the insured's home, vehicles, or personal property
C. To pay the insured's hospital and physician expenses during a period of serious illness
D. To guarantee a stated retirement income to the policyowner beginning at a chosen age

**92. Who is the 'insured' in a life insurance policy?**

A. The insurance company
B. The person whose life is covered by the policy
C. The person who pays the premiums
D. The person who receives the death benefit

**93. What is a 'premium' in life insurance?**

A. The amount the insurer pays at the insured's death
B. The savings element that builds inside the policy
C. The payment made to keep the policy in force
D. The charge deducted when a policy is surrendered early

**94. What does 'face amount' refer to in a life insurance policy?**

A. The annual dividend credited to the policy
B. The cash value available upon surrender
C. The total premiums paid into the policy
D. The death benefit stated in the policy

**95. What is 'insurable interest' in life insurance?**

A. A financial stake in the continued life of the insured
B. The interest rate credited to the policy's cash value
C. The insurer's right to contest a claim for two years
D. The beneficiary's vested right to the policy proceeds

**96. When must insurable interest exist for a life insurance policy to be valid?**

A. Only at the time of death
B. At the time of application
C. Throughout the entire policy period
D. At the time of claim

**97. What is the 'grace period' in a life insurance policy?**

A. The time allowed to reinstate a lapsed policy by paying all back premiums
B. The period during which the insurer may contest statements in the application
C. The time allowed to pay a premium after the due date without policy lapse
D. The time allowed after delivery to return the policy for a full premium refund

**98. What is the standard grace period for life insurance policies?**

A. 7-10 days
B. 10-15 days
C. 60-90 days
D. 30-31 days

**99. What type of life insurance provides coverage for a specific period of time?**

A. Term life insurance
B. Whole life insurance
C. Universal life insurance
D. Variable life insurance

**100. Which type of life insurance has a cash value component that grows over time?**

A. Decreasing term insurance
B. Whole life insurance
C. Annual renewable term
D. Term life insurance

**101. What is 'universal life insurance'?**

A. A permanent policy with fixed level premiums and a guaranteed cash value
B. A temporary policy with level premiums and a death benefit that is fixed for the term
C. A flexible permanent policy with adjustable premiums and death benefits
D. A permanent policy that pays a fixed annual dividend in addition to the death benefit

**102. What distinguishes variable life insurance from whole life insurance?**

A. Variable life guarantees a minimum cash value backed by the general account
B. Variable life premiums are adjusted each year based on investment returns
C. Variable life provides a death benefit for a stated term rather than for life
D. Variable life allows cash value to be invested in sub-accounts

**103. What is 'decreasing term life insurance' typically used for?**

A. Covering a decreasing obligation like a mortgage
B. Providing a guaranteed retirement income stream
C. Accumulating cash value for future policy loans
D. Replacing income that is expected to grow over time

**104. What is a 'convertible term' policy?**

A. A term policy that can be renewed for another term without proof of insurability
B. A term policy that can be converted to permanent insurance without proof of insurability
C. A permanent policy that can be exchanged for a lower-premium term policy at any time after issue
D. A term policy whose accumulated cash value can be converted into an immediate annuity

**105. What is the main difference between whole life and term life insurance?**

A. Whole life covers natural death alone; term covers both natural and accidental death
B. Term life provides lifetime coverage at a lower cost; whole life ends at a stated age
C. Whole life provides lifetime coverage and cash value; term is temporary with no cash value
D. Term life builds cash value faster because its premiums are lower than whole life

**106. What is 'renewable term insurance'?**

A. A term policy that renews only after the insured passes a new medical exam
B. A permanent policy whose premiums are recalculated each year at attained age
C. A term policy that can be exchanged for permanent coverage without a new exam
D. A term policy that can be renewed without proof of insurability

**107. What is the 'incontestability clause' in a life insurance policy?**

A. A provision that limits the insurer's ability to void the policy after 2 years
B. A provision that limits the beneficiary's right to contest a claim denial after 2 years
C. A provision that bars the insurer from adjusting benefits for a misstated age after 2 years
D. A provision that prevents the policyowner from changing the beneficiary after 2 years

**108. Which statement best describes the 'suicide clause' found in most life insurance policies?**

A. A provision allowing the insurer to contest the policy for material misstatements made on the application during its first two years
B. A provision limiting the payout to a refund of premiums if the insured dies by suicide within a stated period after the policy is issued
C. A provision that permanently excludes suicide as a covered cause of death for the entire life of the policy
D. A provision requiring a two-year waiting period before the full death benefit becomes payable for any cause of death

**109. What is a 'policy loan' in life insurance?**

A. A loan from the insurer that is repaid to the beneficiary out of the death benefit
B. An advance of the death benefit paid to the insured after a terminal diagnosis
C. A loan from the insurance company using the policy's cash value as collateral
D. A loan from a lender secured by an assignment of the policy's death benefit

**110. What is the 'waiver of premium' rider?**

A. A provision that waives premiums once the insured reaches age 65
B. A provision that pays a monthly income if the insured becomes disabled
C. A provision that waives the policy's surrender charges after 10 years
D. A provision that waives premiums if the insured becomes disabled

**111. What is an 'accelerated death benefit' rider?**

A. A provision allowing early access to death benefit if terminally ill
B. A provision allowing the beneficiary to collect proceeds before the insured's death
C. A provision that pays the death benefit within 30 days of proof of loss
D. A provision allowing the sale of the policy to a third party for a lump sum

**112. What does the 'guaranteed insurability rider' provide?**

A. The right to convert term coverage to permanent coverage without proof of insurability
B. The right to purchase additional coverage at specified times without proof of insurability
C. The right to reinstate a lapsed policy at any time without proof of insurability
D. The right to increase coverage at any time with the insurer's approval of new evidence of health

**113. What is the 'accidental death benefit' rider?**

A. A provision that waives future premiums if the insured is injured in an accident
B. A provision that pays a monthly income if an accident leaves the insured disabled
C. A provision that pays an additional benefit if death results from an accident
D. A provision that pays the full face amount only if death results from an accident

**114. What is the 'free look period' in life insurance?**

A. The time the insurer has to review the application and issue the policy
B. The time after the due date to pay a premium without the policy lapsing
C. The time the applicant is covered at no cost before the first premium is due
D. The time to review the policy and return it for a full refund

**115. What is a 'primary beneficiary'?**

A. The person(s) first entitled to receive the death benefit
B. The person who owns the policy and controls its rights
C. The person who receives proceeds if the named beneficiary has died
D. The person whose life is covered under the policy contract

**116. What is a 'contingent beneficiary'?**

A. A beneficiary who shares the proceeds equally with the primary beneficiary
B. A backup beneficiary who receives proceeds if the primary is deceased
C. A beneficiary who receives proceeds only if the insured dies by accident
D. A beneficiary whose designation cannot be changed without written consent

**117. What is a 'revocable beneficiary'?**

A. A beneficiary that can be changed only with the beneficiary's consent
B. A beneficiary that the insurer can remove if premiums go unpaid
C. A beneficiary that the policyowner can change at any time
D. A beneficiary that may revoke the policy's settlement option

**118. What is an 'irrevocable beneficiary'?**

A. A beneficiary that the policyowner may change at any time without notice
B. A beneficiary that must be appointed by a probate court
C. A beneficiary that gains rights only after the insured's death

D. A beneficiary that cannot be changed without their written consent

**119. What is the 'lump sum' settlement option?**

A. Paying the entire death benefit in one payment
B. Paying the death benefit in installments
C. Converting the benefit to an annuity
D. Leaving the benefit on deposit with interest

**120. What is the 'interest only' settlement option?**

A. The insurer pays the proceeds in installments that include principal and interest
B. The insurer holds the proceeds and pays only the interest to the beneficiary
C. The insurer pays interest on the death benefit only while the claim is under review
D. The beneficiary receives the proceeds in one payment plus interest accrued since death

**121. What is a 'fixed period' settlement option?**

A. The insurer pays a fixed dollar amount until the proceeds run out
B. The insurer pays the benefit for as long as the beneficiary lives
C. The insurer pays the benefit over a fixed number of years
D. The insurer holds the benefit for a fixed period and then pays a lump sum

**122. What is a 'life income' settlement option?**

A. Income from the policy's cash value
B. A single payment for the beneficiary's lifetime needs
C. Payments until the insured's death
D. Periodic payments for the beneficiary's entire lifetime

**123. What is 'underwriting' in life insurance?**

A. The process of evaluating and classifying risk to determine insurability and premium
B. The process of soliciting applications and delivering policies to applicants
C. The process of investigating and settling claims after a loss has been reported
D. The process of drafting policy forms and filing them with the state for approval

**124. What does 'standard risk' classification mean?**

A. The applicant presents higher-than-average risk and pays a rated premium
B. The applicant presents average risk and qualifies for standard premium rates
C. The applicant presents lower-than-average risk and qualifies for the lowest rates
D. The applicant presents a risk the insurer will accept only with an exclusion rider

**125. What is a 'substandard' or 'rated' policy?**

A. A policy issued to lower-risk applicants at discounted premiums
B. A policy issued with a reduced face amount to average-risk applicants
C. A policy issued to higher-risk applicants with higher premiums
D. A policy that fails to meet the state's minimum benefit standards

**126. What is 'adverse selection' in insurance?**

A. The tendency of insurers to reject applicants with unfavorable health histories
B. The tendency of policyowners to lapse coverage when premiums increase
C. The tendency of producers to place business with the highest-commission insurer
D. The tendency of higher-risk individuals to seek more insurance coverage

**127. What is a 'Medical Information Bureau (MIB)' report?**

A. A database that shares medical information among insurers for underwriting
B. A report from the applicant's physician summarizing their medical history
C. A report on the applicant's character and lifestyle based on interviews
D. A government database of prescription drug records used for underwriting

**128. What is 'preferred risk' classification?**

A. An applicant who presents average risk and qualifies for standard premium rates
B. An applicant who presents lower-than-average risk and qualifies for lower premiums
C. An applicant who presents higher-than-average risk and is charged a rated premium
D. An applicant whose risk the insurer prefers to decline or refer to a substandard carrier

**129. Are life insurance death benefits generally taxable as income to beneficiaries?**

A. Only if the benefit exceeds $100,000
B. Only for term life policies
C. No, death benefits are generally received income tax-free
D. Yes, they are fully taxable

**130. How are cash value withdrawals from a life insurance policy taxed?**

A. Taxed as capital gains on the amount above premiums paid
B. Tax-free as long as the policy remains in force
C. Taxed as ordinary income on the full amount withdrawn
D. Tax-free up to basis (premiums paid), taxable above that

**131. What is a 'Modified Endowment Contract' (MEC)?**

A. A life policy that fails the 7-pay test and loses certain tax advantages
B. A life policy that has been reinstated after lapse under modified terms
C. A life policy whose death benefit is reduced for a misstatement of age
D. A life policy that passes the 7-pay test and keeps its tax advantages

**132. Are premiums paid for personal life insurance tax-deductible?**

A. Yes, they are a deductible medical expense if the taxpayer itemizes
B. No, personal life insurance premiums are generally not tax-deductible
C. Yes, but only the portion of the premium that goes toward cash value
D. No, unless the policy is a term policy with no cash value component

**133. What is an annuity?**

A. A contract that pays a lump-sum death benefit to a named beneficiary
B. A bank deposit account that earns a guaranteed interest rate for a set term
C. A contract that provides periodic income payments, often for retirement
D. A short-term loan secured by the cash value of a permanent life policy

**134. What is a 'fixed annuity'?**

A. An annuity whose payments rise and fall with the performance of sub-accounts
B. An annuity that must be held for a fixed period before it can be annuitized
C. An annuity that pays a fixed amount only for a fixed number of years
D. An annuity with guaranteed minimum interest rates and fixed payments

**135. What is a 'variable annuity'?**

A. An annuity where payments vary based on investment performance
B. An annuity where payments vary based on the insurer's declared interest rate
C. An annuity where the owner may vary the timing and amount of premium payments
D. An annuity where the insurer guarantees a minimum return and bears the risk

**136. What is the 'accumulation period' of an annuity?**

A. When the insurer recalculates payments each year based on returns
B. When premiums are paid and the value grows before payout begins
C. When the annuitant receives periodic income payments from the contract
D. When the contract's value is paid to the beneficiary at the annuitant's death

**137. What is the 'annuitization' or 'payout period'?**

A. When the beneficiary receives the remaining value at the annuitant's death
B. When the owner is paying premiums and the value is growing tax-deferred
C. When the annuity contract converts to periodic income payments

D. When the owner surrenders the contract for its cash value less charges

**138. What is a 'life annuity'?**

A. An annuity that pays a death benefit equal to the face amount at death
B. An annuity that provides income payments for a set number of years
C. An annuity that provides income payments only until the premiums paid are returned
D. An annuity that provides income payments for the annuitant's lifetime

**139. What is a 'period certain' annuity?**

A. An annuity that guarantees payments for a specified period, regardless of survival
B. An annuity that guarantees payments for life but stops when the annuitant dies
C. An annuity that must remain in the accumulation phase for a specified period
D. An annuity that guarantees payments until the total of all premiums paid has been returned

**140. What is 'twisting' in insurance?**

A. Combining multiple policies
B. Misrepresenting or making incomplete comparisons to induce a policyholder to lapse or switch policies
C. A complex policy structure
D. A type of policy endorsement

**141. What is 'churning' in insurance?**

A. Misrepresenting a policy to induce a client to switch insurers
B. Returning part of a commission to a client as an inducement
C. Excessive replacement of policies to generate commissions
D. Rapidly processing applications without proper underwriting

**142. What is 'rebating' in insurance?**

A. Splitting commissions between two licensed producers who both worked on the same sale
B. Returning unearned premium to the policyowner when a policy is cancelled before its term ends
C. Making a false or misleading comparison of policies to induce a policyowner to replace coverage
D. Giving part of the premium or commission back to the insured as an inducement

**143. What is 'misrepresentation' in insurance?**

A. Making false or misleading statements to induce someone to buy insurance
B. Paying a commission to a person who does not hold a valid producer license
C. Placing business with an insurer that is not authorized to do business in the state
D. Returning part of a commission to a client as an inducement to purchase a policy

**144. What is a 'paid-up' life insurance policy?**

A. A policy on which the owner has prepaid the next year's premium at a discounted rate
B. A policy that has lapsed for nonpayment but may still be reinstated within a set period
C. A policy whose death benefit has already been paid in full to the named beneficiary
D. A policy that requires no further premium payments but remains in force

**145. What is a 'reduced paid-up' nonforfeiture option?**

A. Using cash value to purchase a smaller permanent policy with no future premiums
B. Using cash value to purchase term coverage for the full face amount for a limited period
C. Using cash value to pay overdue premiums automatically so the policy does not lapse
D. Surrendering the policy and receiving the cash value in a lump sum minus any loans

**146. What is 'extended term' insurance?**

A. Using cash value to purchase a smaller amount of permanent insurance with no further premiums
B. Using cash value to purchase term insurance for the same face amount for a limited time
C. Renewing an expiring term policy for an additional period without new evidence of insurability
D. Using cash value as a loan to keep the policy in force after the grace period has run out

**147. What is 'group life insurance'?**

A. Life insurance on two lives under one policy that pays the benefit when the first insured dies
B. Individual policies sold to members of an association at a discount, each with its own contract
C. Life insurance provided to a group under a single master policy, typically by an employer
D. Life insurance owned by a business on several key employees with the business as beneficiary

**148. What is 'key person' life insurance?**

A. A policy owned by a key employee, with premiums paid by the business as a fringe benefit
B. A policy owned by a business on an owner, with the owner's family as the beneficiary
C. A policy owned by each partner on the other partners to fund a buy-sell agreement
D. A policy owned by a business on a key employee, with the business as beneficiary

**149. What is a 'buy-sell agreement' in life insurance?**

A. An agreement funded by life insurance that facilitates business ownership transfer upon death
B. An agreement in which a business insures a key employee to offset losses from their death
C. An agreement in which an employer and employee share the premiums and benefits of one policy
D. An agreement in which a policyowner assigns policy rights to a creditor as loan security

**150. What is 'split-dollar' life insurance?**

A. An arrangement where the surviving business owners buy a deceased owner's share using life insurance
B. An arrangement where the cost and benefits of a policy are shared between employer and employee
C. An arrangement where an employer pays a bonus that the employee uses to pay premiums on a policy they own
D. An arrangement where the death benefit is divided between two named beneficiaries in equal shares

**151. Which rider on a universal life policy keeps the coverage in force during the insured's total disability by paying the policy's monthly charges, but not the full planned premium?**

A. The disability income rider
B. The guaranteed insurability rider
C. The waiver of monthly deductions rider
D. The automatic premium loan provision

**152. A life insurance beneficiary receives the death benefit under an installment settlement option that includes a spendthrift clause. What does this clause do?**

A. It protects proceeds still held by the insurer from the beneficiary's creditors and prevents the beneficiary from assigning future payments
B. It lets the insurer reduce payments if the beneficiary mismanages money
C. It allows the policyowner's creditors to claim the death benefit
D. It requires the beneficiary to spend the proceeds only on necessities

**153. Which part of a life insurance policy contains the insurer's basic promise to pay the death benefit to the beneficiary when the insured dies?**

A. The consideration clause
B. The insuring clause
C. The entire contract provision
D. The settlement options section

**154. In most states, the statements an applicant makes on a life insurance application are considered representations. What does that mean?**

A. They are guaranteed to be true in every detail, or the policy is void
B. They must be true only to the best of the applicant's knowledge and belief
C. They are legally binding promises about the applicant's future behavior
D. They cannot be used by the insurer for any purpose after the policy is issued

**155. What does 'paid-up additions' mean?**

A. Small amounts of permanent insurance purchased with dividends
B. Dividends left on deposit with the insurer to accumulate interest
C. One-year term insurance purchased with policy dividends
D. Dividends applied to reduce the next premium payment due

**156. The insured and the primary beneficiary die in the same car crash, and it cannot be proven who died first. Under the Uniform Simultaneous Death Act, how are the proceeds usually distributed?**

A. As though the primary beneficiary died first, so proceeds go to the contingent beneficiary or the insured's estate
B. As though the insured died first, so proceeds pass through the beneficiary's estate
C. Split equally between the two estates
D. Held by the insurer until a court appoints a receiver

**157. An insured dies fifteen days after missing a premium payment, during the policy's grace period. How does the insurer normally handle the claim?**

A. The claim is denied because the premium was unpaid at death
B. The full death benefit is paid and the overdue premium is forgiven
C. The death benefit is paid minus the overdue premium
D. Only the cash surrender value is paid to the beneficiary

**158. A policyowner wants to add level term coverage on his spouse to his own permanent life policy rather than buying the spouse a separate policy. Which rider does this?**

A. A payor benefit rider
B. A return of premium rider
C. A family income rider
D. An other-insured (spouse) term rider

**159. Ten years ago, a father added a 20-year family income rider to his whole life policy. If he dies today, what does the rider pay in addition to the policy's face amount?**

A. Monthly income to the family for the remaining 10 years of the rider period
B. Monthly income to the family for a full 20 years from the date of death
C. A second lump sum equal to the face amount
D. Nothing, because the rider expired when the insured survived 10 years

**160. What is 'cost of insurance' in universal life policies?**

A. The interest credited to cash value at the insurer's current declared rate
B. The mortality charge deducted from cash value to pay for death benefit protection
C. The surrender charge deducted from cash value when the policy is cancelled early
D. The target premium needed to keep the policy in force to the maturity age

**161. What is the 'corridor test' in universal life?**

A. An IRS test limiting the premiums paid in the first seven years to avoid MEC status
B. A state solvency test verifying the insurer's reserves are sufficient to cover its policy obligations
C. An IRS test ensuring minimum death benefit relative to cash value to qualify as life insurance
D. An insurer test requiring the minimum premium be paid to keep the death benefit guaranteed

**162. What is 'table rating' in life insurance?**

A. A system of rating preferred risks with discounted premiums
B. A flat dollar amount added to the premium for a temporary hazard
C. A system of classifying insurers by their financial strength
D. A system of rating substandard risks with higher premiums

**163. What is a 'flat extra' premium?**

A. An additional fixed premium for temporary or specific extra risks
B. A percentage surcharge based on the substandard mortality table assigned
C. A one-time policy fee charged to cover the cost of issuing the policy
D. An additional premium charged for a rider such as waiver of premium

**164. A business is deciding how much key person life insurance to buy on its top salesperson. Which measure is most commonly used to set the coverage amount?**

A. The salesperson's personal debts and mortgage balance
B. The estimated cost of replacing the employee and the profits the business would lose
C. The company's total annual payroll
D. A fixed multiple of the business owner's salary

**165. A sole proprietor wants her longtime manager to buy the business when she dies. They sign an agreement, and the manager buys life insurance on the proprietor to fund the purchase. What is this arrangement called?**

A. An entity purchase plan
B. A cross-purchase plan among partners
C. A one-way buy-sell agreement
D. A split-dollar plan

**166. What is a 'cross-purchase' buy-sell plan?**

A. An arrangement where the business purchases life insurance on each of its owners
B. An arrangement where each business owner purchases life insurance on their own life for their heirs
C. An arrangement where a business purchases life insurance on an employee it cannot easily replace
D. An arrangement where each business owner purchases life insurance on the other owners

**167. What is an 'entity' buy-sell plan?**

A. An arrangement where the business itself purchases life insurance on each owner
B. An arrangement where each owner purchases life insurance on every other owner
C. An arrangement where the business purchases life insurance on a valuable non-owner employee
D. An arrangement where the business pays premiums on a policy owned by each individual owner

**168. Under the endorsement method of a split-dollar life insurance plan, who owns the policy?**

A. The employee owns it and assigns part of the death benefit to the employer
B. The employer owns it and endorses part of the death benefit to the employee's beneficiary
C. The employer and employee own equal shares as joint policyowners
D. An irrevocable trust owns it for the employee's family

**169. Under an employer's group life plan, what does dependent life coverage usually provide?**

A. A small amount of life insurance on the employee's spouse and children, payable to the employee
B. Full income replacement for the family if the employee becomes disabled
C. An equal death benefit for every family member, payable to the insurer
D. Health coverage for dependents after the employee retires

**170. What is 'contributory' group insurance?**

A. A plan where the employer pays the entire premium
B. A plan where the employer contributes to a retirement account
C. A plan where employees may deduct their premiums from taxes
D. A plan where employees pay a portion of the premium

**171. Which life insurance policy is designed to provide coverage for the insured's entire lifetime if premiums are paid as required?**

A. Term life insurance
B. Accidental death insurance
C. Credit life insurance
D. Whole life insurance

**172. Which type of life insurance usually provides protection for a specific number of years and does not build cash value?**

A. Term life
B. Universal life
C. Whole life
D. Variable life

**173. A client wants permanent life insurance with flexible premiums and adjustable death-benefit options. Which policy type is most closely associated with these features?**

A. Straight whole life
B. Universal life
C. Decreasing term
D. Credit life

**174. Which policy is commonly used when the death benefit should decrease over time, such as to help cover a mortgage balance?**

A. Variable universal life
B. Joint life
C. Decreasing term life
D. Whole life

**175. A 55-year-old client pays one large premium and receives a whole life policy that is fully paid up from day one. Which statement about this single-premium whole life policy is accurate?**

A. It has no cash value until the insured reaches age 65
B. It still requires annual premiums to stay in force
C. It has immediate cash value and, under federal tax rules, is generally a modified endowment contract
D. Its death benefit automatically decreases each year

**176. A policyowner wants lifetime protection, level premiums, and guaranteed cash value growth. Which policy best matches that goal?**

A. Straight whole life
B. Accidental death and dismemberment
C. Annual renewable term
D. Decreasing term

**177. Which life policy is written to cover two people and usually pays the death benefit after the first insured dies?**

A. Survivorship life policy
B. Joint life policy
C. Family income policy
D. Group credit policy

**178. A survivorship life policy is most commonly designed to pay the death benefit when:**

A. the policy reaches one year
B. the first insured dies
C. the second insured dies
D. either insured becomes disabled

**179. Credit life insurance is usually written to cover:**

A. a homeowner's liability exposure
B. a hospital expense bill
C. a business inventory loss
D. a borrower's outstanding debt

**180. Which policy feature is most typical of adjustable life insurance?**

A. The policyowner may change coverage elements within policy limits
B. The policyowner directs cash value into separate account subaccounts
C. The policy provides a level face amount for a fixed period of years and then expires
D. The policy's cash value growth is tied to a stock market index

**181. What is the main purpose of a grace period in a life insurance policy?**

A. To cancel the policy immediately after a missed payment
B. To provide extra time to pay a premium after the due date
C. To let the insurer delay all claim payments
D. To increase the policy face amount automatically

**182. A life policy lapses because the premium was not paid. Which provision may allow the policyowner to restore coverage if requirements are met?**

A. Incontestability provision
B. Entire contract provision
C. Reinstatement provision
D. Ownership provision

**183. The entire contract provision generally says the life insurance contract consists of the policy and:**

A. the producer's oral statements made at the time of sale
B. the insurer's sales illustration used during the sale
C. the conditional receipt given when the premium was paid
D. the completed application attached to the policy

**184. What does the incontestability provision generally limit?**

A. The insurer's ability to contest a policy after a stated period, except for limited issues
B. The policyowner's ability to change the beneficiary after a stated period, except with insurer consent
C. The beneficiary's ability to file a claim after a stated period, except for accidental death
D. The insurer's ability to raise premiums after a stated period, except for a change in the insured's health

**185. If the insured's age was misstated on the application, what is the usual policy response?**

A. The policy is voided and all premiums paid are refunded to the beneficiary with interest
B. The death benefit is adjusted to the amount the premium would have purchased at the correct age
C. The death benefit is paid in full and the beneficiary is billed for the premium shortfall
D. The premium is recalculated and the owner must pay the difference before the claim is paid

**186. Which nonforfeiture option uses the cash value to buy paid-up term insurance for the full face amount for a limited period?**

A. Reduced paid-up insurance
B. Cash surrender
C. Extended term insurance
D. Interest-only settlement

**187. Which nonforfeiture option provides a lower amount of permanent coverage with no further premium payments?**

A. Extended term insurance
B. Automatic premium loan
C. Fixed-period settlement
D. Reduced paid-up insurance

**188. What is the free-look period designed to let a new policyowner do?**

A. Cancel the policy after review and receive a refund as required by policy or law
B. Return the policy and receive a refund minus the cost of coverage during the review period
C. Request changes to the policy's terms after delivery without submitting a new application
D. Cancel the policy at any time during the first year and receive a full premium refund

**189. Which provision helps prevent a life policy from lapsing by using policy cash value to pay overdue premiums?**

A. Assignment clause
B. Automatic premium loan
C. Spendthrift clause
D. Common disaster clause

**190. Which settlement option pays life insurance proceeds over a chosen number of years, with payments ending when that period ends?**

A. Lump-sum option
B. Life income
C. Fixed-period option
D. Interest-only option

**191. Who receives the death benefit when the insured dies, assuming the named person or entity is eligible and living?**

A. The reinsurer
B. The producer
C. The underwriter
D. The beneficiary

**192. What is the key difference between a revocable and irrevocable beneficiary?**

A. An irrevocable beneficiary usually must consent to certain beneficiary changes
B. An irrevocable beneficiary may be changed by the policyowner at any time without notice
C. A revocable beneficiary usually must consent before the policy can be assigned or loaned against
D. An irrevocable beneficiary becomes the policyowner once the designation is made

**193. What is the purpose of naming a contingent beneficiary?**

A. To share the benefit equally with the primary beneficiary at the insured's death
B. To receive the benefit if the primary beneficiary cannot receive it
C. To receive the cash value while the primary beneficiary receives the death benefit
D. To become the policyowner if the original owner dies before the insured

**194. A policyowner names three children as per stirpes beneficiaries. One child dies before the insured but has children. What is the usual effect of per stirpes wording?**

A. The policy automatically lapses
B. The surviving beneficiaries always split the deceased child's share equally
C. The deceased child's share may pass to that child's descendants
D. The insurer keeps that share

**195. Which party normally has the right to change a revocable beneficiary?**

A. The producer
B. The primary beneficiary only
C. The exam vendor
D. The policyowner

**196. What does policy assignment usually involve?**

A. Transferring some or all ownership rights in the policy
B. Naming a new insured to replace the original insured
C. Designating which beneficiary will receive the proceeds
D. Transferring the policy to a new insurer at the same rate

**197. A collateral assignment is most often used to:**

A. remove the insured from the policy
B. secure a debt with policy rights as collateral
C. make the agent a beneficiary
D. make a lender the full owner of the insurer

**198. The policyowner is the person who generally has the right to:**

A. approve any beneficiary's claim before the insurer pays it
B. waive underwriting requirements for the insured at application
C. control policy rights such as beneficiary changes and assignments
D. set the policy's premium rate and cost of insurance charges each year

**199. What is a rider in a life insurance policy?**

A. A settlement option chosen by the beneficiary
B. A summary of coverage delivered with the policy
C. A statement of policy value used to illustrate growth
D. An added provision that modifies or adds coverage

**200. Which rider commonly waives premiums if the insured becomes totally disabled according to the rider terms?**

A. Waiver of premium rider
B. Term conversion rider
C. Guaranteed insurability rider
D. Accidental death benefit rider

**201. What does a guaranteed insurability rider usually allow?**

A. Conversion of term coverage to permanent coverage at any time without a new application
B. Purchase of additional coverage at specified times without new proof of insurability
C. Reinstatement of a lapsed policy at specified times without paying back premiums
D. Renewal of the policy at specified times without an increase in premium for attained age

**202. An accidental death benefit rider generally pays an additional benefit when death results from:**

A. any illness after retirement
B. nonpayment of premium
C. a covered accident
D. policy surrender

**203. Which rider is designed to provide part of the death benefit early if the insured has a qualifying terminal illness?**

A. Accidental death benefit rider
B. Guaranteed insurability rider
C. Cost of living adjustment rider
D. Accelerated death benefit rider

**204. A payor benefit rider is most commonly used on a juvenile life policy to:**

A. waive premiums if the adult payor dies or becomes disabled
B. waive premiums if the insured child becomes disabled
C. pay the death benefit to the payor if the child dies
D. allow the child to buy more coverage at specified ages

**205. What does a term rider added to a permanent life policy usually provide?**

A. Additional permanent coverage purchased with dividends
B. Additional temporary life insurance protection
C. A guaranteed minimum interest rate on cash value
D. A waiver of premiums during total disability

**206. A cost-of-living rider is intended to help the policy benefit keep pace with:**

A. the beneficiary's tax filing date
B. the producer's commission schedule
C. inflation
D. the insurer's office rent

**207. In life insurance, which process is the insurer carrying out when it reviews an applicant before deciding whether to issue a policy?**

A. The process of adjusting a claim after the insured's death
B. The process of setting mortality rates for a class of insureds
C. The process of delivering the policy and collecting the first premium
D. The process of evaluating risk before issuing coverage

**208. Which item is commonly used by life insurers during underwriting?**

A. Application information and health history
B. A beneficiary's favorite investment account
C. The producer's personal opinion only
D. The state capital city

**209. What does insurable interest generally require at policy issue?**

A. A financial interest that the beneficiary must hold at the time of the insured's death
B. A valid financial or personal interest in the continued life of the insured
C. A blood or marital relationship between the insured and every named beneficiary
D. A written consent from the insured that must be renewed each time a premium is paid

**210. A stranger with no relationship to the insured applies for a policy on the insured's life for speculative gain. What principle is most directly violated?**

A. Principle of indemnity
B. Utmost good faith
C. Insurable interest
D. Adverse selection

**211. A premium is best described as:**

A. the amount the insurer pays the beneficiary at the insured's death
B. the fee the policyowner pays to take out a loan against cash value
C. the portion of the premium the producer keeps as a commission
D. the payment required to keep insurance coverage in force

**212. Which risk classification usually receives a lower premium because the applicant presents better-than-average mortality risk?**

A. Preferred
B. Declined
C. Rated-up only
D. Substandard

**213. A substandard life insurance risk is most likely to receive:**

A. the same premium as a standard risk with a longer grace period
B. a higher premium or rating because of increased risk
C. a preferred classification with a discounted premium
D. an automatic decline with no option to be rated

**214. Why must a producer avoid altering an applicant's answers without proper authorization?**

A. It changes the state exam vendor
B. It guarantees a higher commission
C. Application accuracy is important to underwriting and contract validity
D. It makes the policy automatically tax-free

**215. What is the primary purpose of an annuity?**

A. To replace auto liability coverage
B. To insure a house against fire
C. To pay a death benefit only after accidental death
D. To provide income, often during retirement

**216. During the accumulation period of a deferred annuity, the owner is primarily:**

A. building value before income payments begin
B. filing a property claim
C. changing the insured every month
D. receiving workers compensation benefits

**217. What happens during the annuitization or payout phase?**

A. The owner continues to make premium deposits that grow tax-deferred
B. The accumulated value is converted into a stream of income payments
C. The surrender charge schedule resets and the accumulation period begins again
D. The full accumulated value is paid to the beneficiary as a death benefit

**218. Which annuity payout option generally provides payments for as long as the annuitant lives, with no guarantee to beneficiaries after death?**

A. Refund life option
B. Fixed-period option
C. Life-only option
D. Joint-and-survivor option

**219. What is a surrender charge in an annuity?**

A. A penalty the IRS assesses on any withdrawal taken before age 59 1/2
B. A charge deducted from each premium payment to cover the insurer's sales expenses
C. A fee the insurer charges the beneficiary when the annuitant dies before payout
D. A fee that may apply when funds are withdrawn during a stated early period

**220. What distinguishes an immediate annuity from a deferred annuity?**

A. An immediate annuity generally begins income payments soon after purchase
B. An immediate annuity may be funded with a series of periodic premium payments
C. A deferred annuity must begin income payments within one year of purchase
D. An immediate annuity offers a longer accumulation period than a deferred annuity

**221. For federal income tax purposes, life insurance death benefits paid in a lump sum to a beneficiary are generally:**

A. taxed only if the insured was under age 65
B. received income tax-free
C. always taxed as ordinary income
D. paid only after a probate court approves the insurer

**222. Which part of a life insurance settlement option may be taxable to the beneficiary?**

A. The producer's appointment
B. The policy number
C. Interest earned on retained proceeds
D. The beneficiary designation itself

**223. Cash value growth inside a permanent life insurance policy is generally taxed:**

A. as ordinary income in the year the interest is credited
B. as a capital gain reported annually by the policyowner
C. as fully tax-exempt income, including any gain taken at surrender
D. on a tax-deferred basis while it remains in the policy

**224. A policyowner withdraws more than the cost basis from a life insurance policy. The excess is generally treated as:**

A. taxable income
B. an automatic beneficiary change
C. a new death benefit
D. a premium discount

**225. Life insurance policy loans are generally:**

A. taxable as ordinary income in the year the loan is received
B. not taxable when taken, if the policy remains in force
C. taxable to the beneficiary when the death benefit is later paid
D. limited to the premiums paid and free of interest charges

**226. Premiums paid for an individual life insurance policy are generally:**

A. deducted only by the beneficiary
B. fully deductible by every policyowner
C. not deductible as a personal expense
D. treated as state exam fees

**227. If a life insurance policy is surrendered for more than the policyowner's cost basis, the gain is generally:**

A. converted into auto insurance
B. paid to the producer
C. ignored for all tax purposes
D. taxable as ordinary income

**228. Which phrase best describes the tax treatment of qualified retirement annuity contributions?**

A. They may receive special tax treatment under retirement-plan rules
B. They are taxed in the year contributed and again when distributed
C. They are treated the same as premiums on a nonqualified annuity
D. They produce earnings that are taxed annually as ordinary income

**229. A modified endowment contract, or MEC, is important because it can change:**

A. the income tax treatment of the death benefit
B. the tax treatment of distributions from the policy
C. the guaranteed cash value schedule in the contract
D. the contestability period the insurer may rely on

**230. Which statement about estate taxation and life insurance is most accurate?**

A. Proceeds paid to a named beneficiary are excluded from the estate regardless of who owned the policy
B. Proceeds are subject to federal estate tax whenever the beneficiary is a family member
C. Ownership and incidents of ownership can affect whether proceeds are included in an estate
D. Transferring ownership of the policy to another person is disregarded for estate tax purposes

**231. Group life insurance is typically issued under:**

A. a homeowners policy form
B. a court order after the insured dies
C. a separate policy mailed to each beneficiary only
D. a master policy issued to the group sponsor

**232. In employer group life insurance, the individual covered employee usually receives:**

A. a certificate of insurance
B. the original master policy
C. the insurer's corporate charter
D. a state exam outline

**233. Group underwriting usually focuses most on:**

A. only one employee's favorite hobby
B. the group as a whole
C. the producer's continuing education record
D. the beneficiary's credit card limit

**234. A contributory group life plan means:**

A. the employer pays nothing and no one is insured
B. only retirees may enroll
C. covered members pay part or all of the premium
D. the insurer pays the employee's salary

**235. A noncontributory group life plan usually requires:**

A. beneficiaries to pay the premium after death
B. each employee to pass an individual medical exam
C. coverage to be converted to auto insurance
D. the employer or sponsor to pay the premium

**236. The conversion privilege in group life insurance usually allows a departing employee to:**

A. convert group coverage to an individual policy without proving insurability
B. convert to an individual term policy after passing a new medical examination
C. continue the group coverage at the group rate for as long as premiums are paid
D. transfer the group certificate to a new employer's plan without a waiting period

**237. Why do group life plans often have eligibility rules?**

A. To allow the insurer to underwrite each employee individually
B. To define who can participate and help control adverse selection
C. To require every employee to name the employer as beneficiary

D. To let the employer select which employees receive the largest benefit

**238. In many employer group life plans, coverage amounts are commonly based on:**

A. the number of claims paid by the auto insurer
B. the producer's commute distance
C. salary, job class, or a flat benefit schedule
D. the employee's favorite beneficiary

**239. A key advantage of group life insurance for employees is that it often provides:**

A. property coverage for every employee's home
B. unlimited investment returns with no risk
C. automatic licensing as an insurance producer
D. basic coverage at a lower or employer-supported cost

**240. Which risk is group life eligibility and participation design intended to reduce?**

A. Adverse selection
B. Physical hazard
C. Misrepresentation
D. Speculative risk

**241. A buy-sell agreement funded with life insurance is commonly used to:**

A. replace lost profits while a key employee recovers
B. help transfer a deceased owner's business interest
C. fund a deferred compensation promise to an executive
D. pay off the company's debts to its general creditors

**242. Key person life insurance is designed to protect a business from:**

A. the cost of purchasing a deceased partner's share of the business
B. liability claims brought by the families of employees who die on the job
C. financial loss caused by the death of an important employee or owner
D. the obligation to pay death benefits to a key employee's family

**243. In a typical key person policy, who is usually the policyowner and beneficiary?**

A. The employee's neighbor
B. The exam vendor
C. The state insurance department
D. The business

**244. A cross-purchase buy-sell plan usually involves:**

A. business owners buying policies on each other
B. the business buying auto insurance for all customers
C. an insurer purchasing the state exam vendor
D. a beneficiary buying the master group policy

**245. An entity-purchase buy-sell plan usually means:**

A. each owner owns a policy on every other owner and buys the deceased owner's interest
B. the business owns policies on the owners and buys the deceased owner's interest
C. the deceased owner's heirs own the policy and keep the business interest
D. the surviving owners personally pay the estate from their own after-tax income

**246. Which business use of life insurance helps provide benefits to selected executives?**

A. Cross-purchase agreement
B. Key person life insurance
C. Executive bonus arrangement
D. Business overhead expense policy

**247. Business continuation planning with life insurance is mainly concerned with:**

A. replacing an executive's salary during a temporary disability
B. providing retirement income to all rank-and-file employees
C. insuring the company's inventory and equipment against loss
D. providing funds after an owner's or key person's death

**248. Why is insurable interest important in business life insurance?**

A. The business must have a legitimate interest in the insured person's continued life
B. The insured employee must have an ownership stake in the business before coverage is issued
C. The insurable interest must continue to exist at the time the death claim is paid
D. The business must name the insured's family as the beneficiary of the policy

**249. Which situation best fits key person life insurance?**

A. Two partners each buy a policy on the other to fund the purchase of a deceased partner's share
B. A company buys coverage on a founder whose death would harm business operations
C. A company pays the premium on a policy an executive owns as a form of extra compensation
D. A company provides group term coverage to every full-time employee on the payroll

**250. Which document usually controls how ownership interests are transferred in a buy-sell arrangement?**

A. The beneficiary's driver's license
B. The producer's business card
C. The buy-sell agreement
D. The insurer's advertising flyer

**251. A settlement option determines:**

A. how a producer's commission is reported to the insurer
B. which state administers the licensing exam
C. whether a home has replacement cost coverage
D. how life insurance proceeds are paid to a beneficiary

**252. Under the interest-only settlement option, the insurer generally:**

A. holds the proceeds and pays interest to the beneficiary
B. pays equal installments of principal and interest for a set period
C. pays the beneficiary a guaranteed income for the rest of her life
D. pays the full proceeds in a single lump sum plus any accrued interest

**253. A fixed-period settlement option pays proceeds:**

A. only if the beneficiary passes an exam
B. over a selected period of time
C. until the insurer changes its logo
D. only as a single lump sum

**254. A fixed-amount settlement option pays:**

A. equal installments spread over a chosen number of years, regardless of amount
B. a guaranteed income for life that ends at the beneficiary's death
C. a selected dollar amount at regular intervals until funds are exhausted
D. interest on the retained proceeds while the principal stays with the insurer

**255. Which settlement option is most directly tied to the beneficiary's lifetime?**

A. Lump-sum option only
B. Interest-only option
C. Fixed-period option
D. Life income option

**256. Nonforfeiture options are important because they protect:**

A. the policyowner's equity in a permanent life policy if premiums stop
B. the beneficiary's right to choose how the death benefit is paid out
C. the insurer from paying a claim when the policy lapses during the grace period
D. the policyowner's dividends in a participating term policy after it expires

**257. The cash surrender nonforfeiture option generally allows the policyowner to:**

A. use the cash value to buy paid-up coverage for a reduced face amount
B. receive the policy's available cash value and end the policy
C. borrow against the cash value while keeping the full death benefit
D. receive the cash value in installments while the coverage continues

**258. The reduced paid-up nonforfeiture option generally uses cash value to buy:**

A. a health insurance deductible
B. a larger policy requiring higher future premiums
C. a smaller amount of fully paid-up life insurance
D. a producer's license renewal

**259. The extended term nonforfeiture option generally uses cash value to provide:**

A. an annuity that starts immediately for all beneficiaries
B. a permanent policy with a larger face amount forever
C. property liability coverage
D. term insurance for the original face amount for a limited period

**260. Which option usually provides immediate access to the policy's available cash value but ends the life coverage?**

A. Cash surrender
B. Reduced paid-up insurance
C. Automatic premium loan
D. Extended term insurance

**261. Insurance replacement rules are mainly intended to protect consumers from:**

A. insurers that refuse to renew existing coverage
B. unsuitable or misleading policy changes
C. producers selling without a valid license
D. unpaid claims after a policy lapses

**262. A producer recommends replacing a life policy but fails to discuss surrender charges and new contestability periods. What is the concern?**

A. The exam vendor must approve the sale
B. The beneficiary becomes the insurer
C. The recommendation may be misleading or unsuitable
D. The policy automatically becomes group insurance

**263. Twisting generally refers to:**

A. offering part of the commission as an inducement to buy
B. making false statements about an insurer's financial condition
C. requiring a client to buy insurance as a condition of a loan
D. using misleading information to induce a policy replacement

**264. Rebating is generally best described as:**

A. offering an unlawful inducement not stated in the policy
B. misrepresenting policy terms to induce a replacement
C. charging different rates to insureds of the same class
D. returning unearned premium after a policy is cancelled

**265. A producer's ethical duty when explaining a life policy is to:**

A. emphasize the benefits and leave exclusions to the policy text
B. present material information accurately and fairly
C. recommend the policy that pays the highest commission
D. rely on the illustration in place of the policy provisions

**266. When replacing existing coverage, why is the new contestability period important?**

A. The old policy's contestability period carries over to the replacement policy
B. The new policy cannot be contested because the insured was already underwritten once
C. The new policy may start a new period during which misstatements can be contested
D. The new policy's contestability period is shortened to the time remaining on the old policy

**267. Which action is most consistent with fair life insurance sales practice?**

A. Advising the client to surrender the old policy before the new one is approved
B. Recommending the policy with the highest first-year commission to the producer
C. Presenting the new policy's illustration as a guaranteed projection of values
D. Comparing old and new coverage honestly before recommending replacement

**268. Which statement is a red flag for misrepresentation?**

A. This policy is guaranteed to solve every financial problem with no risk or cost
B. This policy's cash value grows tax-deferred, but a surrender may produce a taxable gain
C. The illustrated values that are not guaranteed may be higher or lower than shown
D. You have a free-look period after delivery during which you may return the policy

**269. A buyer's guide or policy summary is used to help the applicant:**

A. acknowledge receipt of the policy and start the free-look period
B. understand important policy features and compare coverage
C. satisfy the insurable interest requirement at policy issue
D. authorize the insurer to obtain medical and credit information

**270. Why should a producer document important client conversations and recommendations?**

A. Documentation transfers responsibility for suitability from the producer to the client
B. Documentation is required before the insurer can issue a binding receipt
C. Documentation helps show what was discussed and why a recommendation was made
D. Documentation protects the producer from any claim of misrepresentation

**271. Contributions made to a Roth IRA receive which federal income tax treatment in the year they are made?**

A. They are deductible only if the owner has no employer plan
B. They are fully deductible regardless of income
C. They are made with after-tax dollars and are not deductible
D. They reduce the owner's Social Security wage base

**272. A taxpayer takes money out of a traditional IRA at age 50 and does not qualify for any exception. In addition to ordinary income tax, what generally applies?**

A. A 25 percent excise tax
B. A 20 percent mandatory withholding on eligible rollover distributions
C. A 6 percent excess contribution tax
D. A 10 percent early distribution penalty

**273. Which characteristic best distinguishes a Roth IRA from a traditional IRA for the original account owner?**

A. The Roth owner is not required to take minimum distributions during his or her lifetime
B. The Roth owner may deduct contributions in the year they are made, while the traditional owner may not
C. Earnings in a Roth accumulate tax-deferred, while earnings in a traditional IRA are taxed each year
D. The Roth owner must begin distributions at an earlier age than the traditional IRA owner

**274. A tax-sheltered annuity, also called a 403(b) plan, is available to employees of which type of organization?**

A. Publicly traded for-profit corporations and their subsidiaries
B. Public school systems and qualifying 501(c)(3) nonprofit organizations
C. Federal government agencies and members of the uniformed services
D. Self-employed persons and partnerships with no common-law employees

**275. Which statement accurately describes how a Simplified Employee Pension, or SEP, is funded?**

A. Employees fund the plan by pre-tax salary reduction, and the employer must match
B. The employer funds a single pooled trust and allocates benefits by final salary
C. The employer makes contributions into an IRA established for each eligible employee
D. Employees make after-tax contributions that are later withdrawn income-tax free

**276. A SIMPLE plan is generally designed for an employer with how many employees?**

A. At least 500 employees
B. Exactly 50 employees
C. Any number, with no size limit
D. 100 or fewer eligible employees

**277. A terminating participant asks that her qualified plan balance be paid directly to her so she can redeposit it in an IRA within 60 days. What is the tax consequence of taking possession of the funds?**

A. The plan must withhold 20 percent of the eligible rollover distribution for federal income tax
B. No withholding applies because the funds are being rolled over within the 60-day window
C. The entire distribution becomes taxable immediately and permanently loses its eligibility for rollover
D. The plan must withhold a 10 percent early-distribution penalty regardless of her age

**278. What is the most important tax difference between a qualified retirement plan and a nonqualified deferred compensation arrangement?**

A. Nonqualified plans must satisfy stricter coverage and nondiscrimination rules than qualified plans in order to earn a deduction
B. Employer contributions to a qualified plan are currently deductible, while nonqualified plan deductions are generally postponed
C. Earnings in a qualified plan are taxed to the employee each year, while nonqualified plan earnings grow tax deferred
D. Benefits from a qualified plan are received income tax free, while nonqualified plan benefits are taxed as ordinary income

**279. Elective salary deferrals made by an employee into a traditional 401(k) plan are best described as:**

A. Included in the employee's current taxable income and received tax free when distributed
B. Deductible by the employee as an itemized deduction on Schedule A in the year deferred
C. Excluded from the employee's current taxable income and taxed when distributed
D. Excluded from current income, with the earnings portion alone taxed at distribution

**280. Which statement about required minimum distributions from a traditional IRA is accurate?**

A. They must begin by April 1 of the year after the owner reaches age 59 1/2
B. They may be postponed indefinitely as long as the owner names a spouse as sole beneficiary
C. They may be delayed past the required beginning date while the owner is still working
D. Failing to withdraw the required amount triggers an additional tax on the shortfall

**281. A producer's authority to complete applications and collect initial premiums, even though the agency contract never lists those specific tasks, is an example of what kind of authority?**

A. Implied authority
B. Express authority
C. Fiduciary authority
D. Apparent authority

**282. An insurer allows a terminated producer to keep using company signs, stationery, and application forms. A consumer reasonably believes the producer still represents the insurer. Which concept most directly binds the insurer?**

A. Express authority
B. Apparent authority
C. Concealment
D. Implied authority

**283. An insurance contract is called aleatory because:**

A. The insurer's promise to pay becomes enforceable once the stated policy conditions have been met
B. The applicant must accept the contract as drafted by the insurer without negotiating any of its terms
C. The dollar amounts exchanged by the parties may be very unequal and depend on an uncertain event
D. The insurer alone makes a legally enforceable promise, since the insured merely pays premiums

**284. Ambiguous language in a life insurance policy is generally interpreted in favor of the policyowner. This result flows from which contract characteristic?**

A. Aleatory
B. Unilateral
C. Conditional
D. Adhesion

**285. On a life insurance application, statements made by the applicant are generally treated as:**

A. Representations believed to be true to the best of the applicant's knowledge
B. Warranties that must be literally true in every detail for the policy to remain valid
C. Statements of opinion that cannot support a rescission even if materially false
D. Legal conclusions binding on the insurer once the policy has been delivered and accepted

**286. An applicant deliberately says nothing about a recent hospitalization for a heart condition that the application asked about. This is best described as:**

A. Subrogation
B. Concealment
C. Waiver
D. Estoppel

**287. An insurer knowingly accepts a late premium several times without objection and later tries to deny a claim solely because that same premium was late. The insurer is most likely blocked by:**

A. Insurable interest
B. Adverse selection
C. Estoppel
D. Indemnity

**288. Which pair of individuals would most clearly satisfy the insurable interest requirement at the time a life policy is applied for?**

A. A neighbor insuring the life of the family next door who sometimes watch her home
B. A charity insuring the life of a prospective donor it has approached once by mail
C. An investor insuring the life of a stranger in poor health in exchange for a cash payment
D. A business partner insuring the life of a co-owner under a buy-sell arrangement

**289. The principle of utmost good faith in life insurance means that:**

A. Both parties are expected to deal honestly and disclose material facts
B. The insurer alone must disclose material facts, since it drafted the policy language
C. The applicant alone must disclose material facts, since the insurer relies on the answers
D. The insurer must pay any claim submitted in good faith by the beneficiary

**290. Insurers use medical underwriting, waiting periods, and eligibility rules primarily to combat which tendency?**

A. Reciprocity
B. Adverse selection

C. The law of large numbers

D. Indemnity

**291. Why is the law of large numbers essential to insurance pricing?**

A. It permits the insurer to charge every applicant in the pool an identical rate regardless of risk class

B. It allows an insurer with enough exposure units to operate without holding reserves for future claims

C. As the number of similar exposure units grows, actual results come closer to predicted results

D. As the number of exposure units grows, the chance that any individual insured suffers a loss declines

**292. Which statement best explains why life insurance is often described as a valued contract rather than a strict contract of indemnity?**

A. The beneficiary must submit receipts to substantiate the loss

B. Death benefits are limited to documented funeral expenses

C. The insurer may reduce the benefit to the beneficiary's actual economic loss

D. The stated face amount is paid regardless of the precise dollar value of the loss

**293. Which exchange qualifies for tax-free treatment under Internal Revenue Code Section 1035?**

A. A life insurance policy exchanged for an annuity contract

B. An annuity contract exchanged for a life insurance policy

C. An annuity contract exchanged for a certificate of deposit

D. A life insurance policy exchanged for shares of stock

**294. A life insurance policy becomes a modified endowment contract when it:**

A. Has a face amount above one million dollars

B. Is funded faster than the seven-pay test permits

C. Contains a waiver of premium rider

D. Is issued to an applicant over age 65

**295. How are lifetime distributions from a modified endowment contract taxed?**

A. On a first-in, first-out basis, so nontaxable cost basis is recovered first

B. As entirely tax-free withdrawals, since the contract is still life insurance

C. On a last-in, first-out basis, so taxable gain is treated as coming out first

D. As long-term capital gain to the extent the distribution exceeds premiums

**296. The exclusion ratio applied to payments from a nonqualified immediate annuity is used to determine:**

A. The portion of each payment that must be withheld and remitted as federal income tax

B. The portion of the account value that may be withdrawn each year free of surrender charges

C. The minimum guaranteed interest rate the insurer must credit during the payout period

D. The portion of each payment treated as a tax-free return of the owner's investment

**297. A beneficiary elects to leave a $250,000 death benefit with the insurer under an interest-only option. How is the arrangement taxed?**

A. The principal remains income-tax free and the interest payments are taxable income

B. The interest payments are tax free and the principal is taxable when finally withdrawn

C. Both the principal and the interest are taxable because the beneficiary elected to defer

D. Both the principal and the interest are tax free because they arise from a death benefit

**298. A policyowner takes a $20,000 loan against a whole life policy that is not a modified endowment contract and the policy remains in force. What is the income tax result?**

A. The entire loan is taxable as ordinary income

B. The loan is generally not a taxable event

C. The loan is taxable only to the extent it exceeds the death benefit

D. The loan is treated as a capital gain

**299. Annual dividends paid on a participating whole life policy are generally treated for federal income tax purposes as:**

A. Taxable only if paid in cash
B. A long-term capital gain
C. A nontaxable return of excess premium
D. Fully taxable ordinary income when received

**300. A policyowner surrenders a life policy with $60,000 of cash value after paying $45,000 in total premiums. What is the general tax treatment?**

A. The $15,000 gain is taxable as a long-term capital gain
B. Nothing is taxable because life insurance proceeds are exempt
C. The full $60,000 is taxable
D. The $15,000 gain above basis is taxable as ordinary income

**301. Under the transfer-for-value rule, which transfer would generally preserve the income-tax-free status of the death benefit?**

A. Sale of the policy to the insured or to a partner of the insured
B. Sale of the policy to an unrelated investor for cash
C. Sale of the policy to a competitor of the insured's employer
D. Sale of the policy to a friend of the insured

**302. Cash value accumulating inside a permanent life insurance policy receives which tax treatment while the policy is in force?**

A. It is subject to self-employment tax
B. It grows tax deferred and is not reported annually
C. It is taxed each year as interest income
D. It is taxed at capital gains rates each year

**303. An employer pays the premium on $75,000 of group term life insurance for an employee. What is the general federal income tax result to the employee?**

A. The full premium is taxable to the employee as additional wages
B. The premium is excluded entirely because group coverage is a fringe benefit
C. The cost of coverage above $50,000 is imputed income to the employee
D. The employee may deduct the premium personally as an adjustment to income

**304. A partial withdrawal is taken from a nonqualified deferred annuity before annuitization has begun. How is the withdrawal generally taxed?**

A. Entirely as a tax-free return of principal
B. As principal first, with earnings taxed only at annuitization
C. At long-term capital gains rates
D. As earnings first, which are taxed as ordinary income

**305. Under a universal life policy with the level death benefit arrangement, commonly called Option A, the death benefit:**

A. Increases each year by the amount of interest credited to the cash value
B. Stays level, with the pure insurance element shrinking as cash value grows
C. Equals the face amount plus the accumulated cash value at death
D. Stays level, with the pure insurance element growing as cash value builds

**306. To sell a variable universal life policy, a producer must generally hold:**

A. Both a state life insurance license and a securities registration
B. A state life insurance license, since the insurer holds the securities registration
C. A federal securities registration, which preempts the state life license requirement
D. A state life license and a state investment adviser registration

**307. Cash values in a variable life insurance policy are held in:**

A. A federally insured bank deposit

B. An escrow account managed by the state

C. Separate accounts, where the policyowner bears the investment risk

D. The insurer's general account, with a guaranteed minimum rate

**308. Which statement most accurately describes an indexed universal life policy?**

A. The policyowner's premiums are invested directly in the shares that make up the chosen stock index

B. Cash value is held in separate account subaccounts and fluctuates daily with their net asset value

C. Interest credited is guaranteed to match the full index return each year, including reinvested dividends, with no cap applied

D. Interest credited is linked to an external index, subject to features such as a floor, cap, or participation rate

**309. A married couple wants one policy that pays only after both of them have died, in order to provide funds for estate settlement costs. Which policy fits best?**

A. Survivorship life, also called second-to-die

B. Joint life, also called first-to-die

C. Two separate term policies with a common beneficiary

D. A family policy with spouse and child riders

**310. An endowment policy is distinguished by the fact that it:**

A. Pays the face amount at death but returns the premiums paid, not the face amount, if the insured outlives the term

B. Pays the face amount if the insured survives to a stated maturity date, or at earlier death

C. Builds cash value more slowly than whole life because it is designed to mature at age 100

D. Pays the face amount at death alone, with the cash value forfeited if the insured survives to maturity

**311. In a typical credit life insurance arrangement, the beneficiary is:**

A. The borrower's estate, which then repays the creditor

B. The borrower's surviving spouse or dependent children

C. The creditor, up to the amount of the outstanding debt

D. The creditor, for the full original amount of the loan

**312. A modified premium whole life policy is structured so that premiums are:**

A. Higher during the early policy years and lower in later years

B. Adjustable each year by the policyowner within stated limits

C. Level for the entire premium-paying period of the contract

D. Lower during the early policy years and higher in later years

**313. An insured converts a convertible term policy to permanent coverage. Which statement is correct?**

A. No evidence of insurability is required, and the permanent premium reflects the conversion basis used

B. The new premium is always based on the insured's age when the term policy was first issued

C. The conversion may be denied if the insured's health has declined

D. The insured must submit to a new medical examination

**314. Which feature is characteristic of a joint life, or first-to-die, policy?**

A. The benefit is paid only after both insureds have died

B. One death benefit is paid when the first of the covered insureds dies

C. A separate death benefit is paid for each insured

D. Coverage automatically terminates when either insured turns 65

**315. Which annuity settlement option produces the largest monthly income from a given amount of accumulated value?**

A. Installment refund

B. Life with 20-year period certain

C. Straight life, also called pure life

D. Joint and full survivor

**316. An annuitant selects a life with 10-year period certain option and dies in the sixth year. What happens?**

A. The beneficiary receives a refund of all payments already made
B. Payments stop immediately
C. The beneficiary receives payments for another 10 years
D. The beneficiary receives payments for the remaining four years

**317. A cash refund annuity provides that if the annuitant dies before receiving payments equal to the amount paid into the contract:**

A. The beneficiary receives the unrecovered balance in a lump sum
B. The beneficiary receives the unrecovered balance in continued installments
C. The insurer retains the balance as the price of the lifetime guarantee
D. Payments continue to the beneficiary for the rest of the beneficiary's life

**318. Under a joint and two-thirds survivor annuity, what happens after the first annuitant dies?**

A. The survivor receives one-third of the original joint payment for life
B. The survivor receives two-thirds of the original joint payment for life
C. The survivor receives the full joint payment until the account value is exhausted
D. The survivor receives two-thirds of the original joint payment for a fixed period certain

**319. What is the fundamental difference between an immediate annuity and a deferred annuity?**

A. The immediate annuity may be purchased with a single premium alone, while a deferred annuity must be funded with periodic premiums
B. The immediate annuity is available in fixed form alone, while a deferred annuity may be issued as either a fixed or variable contract
C. The immediate annuity begins income payments within about one payment period of purchase, while a deferred annuity accumulates first
D. The immediate annuity begins income payments after a one-year waiting period, while a deferred annuity pays income from the date of purchase

**320. In a fixed annuity, who bears the investment risk during the accumulation period?**

A. The annuitant
B. The federal government
C. The beneficiary
D. The insurance company

**321. Before recommending that a client purchase or replace an annuity, a producer's suitability obligation requires that the producer:**

A. Gather information on the client's financial situation, objectives, and needs and have reasonable grounds for the recommendation
B. Obtain written approval of the recommendation from the client's attorney or accountant before the application is signed
C. Rely on the client's stated interest in the product, since a consumer's own request satisfies the suitability standard
D. Submit the completed consumer profile form to the state insurance department for review and approval before the sale can be completed

**322. An indexed annuity differs from a traditional fixed annuity primarily because:**

A. Its cash value is invested directly in the securities that make up the index, so it carries no minimum guarantee
B. Its credited interest is tied to the performance of an external market index, subject to a floor and limiting features
C. It must be registered as a security with the SEC and sold by a producer who holds a securities registration
D. It credits a fixed rate declared in advance each year and cannot be annuitized into a guaranteed lifetime income

**323. Which dividend option uses the dividend to purchase a small amount of additional permanent coverage that immediately has its own cash value?**

A. Accumulate at interest
B. Cash payment
C. Paid-up additions

D. Reduce premium

**324. The fifth dividend option, sometimes called the one-year term option, uses the dividend to:**

A. Buy single-premium paid-up additions that increase the policy's face amount permanently
B. Prepay the next annual premium, with any excess held at interest for one year
C. Pay up the policy one year sooner than the original premium schedule provides
D. Buy one-year term insurance, often in an amount related to the policy's cash value

**325. Which statement about policy dividends is accurate?**

A. They are not guaranteed and depend on the insurer's mortality, expense, and investment results
B. They are guaranteed by the contract once the policy has been in force for a stated number of years
C. They are taxable as ordinary income when paid, because they represent a share of the insurer's earnings
D. They are paid by stock insurers on nonparticipating policies out of the shareholders' surplus

**326. A policyowner elects the accumulate at interest dividend option. Which statement is correct?**

A. The dividend is taxable as ordinary income when credited, but interest earned on it is tax deferred
B. The dividend remains a nontaxable return of premium, but the interest credited on it is taxable income
C. Both the dividend and the interest are tax free because the funds stay in a life insurance contract
D. Both the dividend and the interest are taxed as ordinary income in the year the dividend is declared

**327. What is the key difference between participating and nonparticipating life insurance policies?**

A. Nonparticipating policies are eligible to receive policy dividends, while participating policies are not
B. Participating policies are issued by stock insurers, while nonparticipating policies are issued by mutual insurers
C. Participating policies are eligible to receive policy dividends, while nonparticipating policies are not
D. Participating policies build guaranteed cash value, while nonparticipating policies build cash value from dividends alone

**328. To be fully insured for Social Security purposes, a worker generally must have earned:**

A. 6 credits in the last 13 quarters
B. 20 quarters of coverage
C. 120 quarters of coverage
D. 40 quarters of coverage

**329. The Social Security blackout period refers to the span during which:**

A. A surviving spouse receives no Social Security survivor income
B. A surviving spouse's benefit is reduced for claiming before full retirement age
C. A worker's earnings record is frozen and no further credits can be earned
D. A surviving spouse's benefit is withheld until the youngest child reaches age 16

**330. Which survivor is generally eligible for Social Security benefits based on a deceased worker's record?**

A. A dependent parent under age 62 of the worker
B. An unmarried dependent child under age 18
C. An adult sibling who lived with the worker
D. A business partner who depended on the worker

**331. Marta owns a universal life policy with a $300,000 specified amount and the increasing death benefit arrangement, commonly called Option B. When she dies, the policy's cash value is $40,000. How much does her beneficiary receive?**

A. $300,000, because the specified amount is the most the insurer ever pays
B. $340,000, because Option B pays the specified amount plus the accumulated cash value
C. $260,000, because the cash value is deducted from the specified amount at death
D. $40,000, because Option B substitutes the cash value for the specified amount

**332. Theo, age 35, owns a universal life policy being tested under the guideline premium and cash value corridor rules of IRC Section 7702. His cash surrender value has grown to $100,000. To remain a life insurance contract for tax purposes, what is the minimum death benefit the policy must provide?**

A. $100,000, equal to the cash surrender value
B. $105,000, or 105 percent of the cash surrender value

C. $250,000, or 250 percent of the cash surrender value

D. $150,000, or 150 percent of the cash surrender value

**333. Priya stopped paying premiums on her universal life policy three years ago, assuming the coverage would simply continue because premiums are 'flexible.' She just received a notice that her policy is about to terminate. What most likely happened?**

A. Monthly deductions for the cost of insurance and expenses continued and have nearly exhausted her cash value

B. The insurer canceled the policy for nonpayment at the end of the standard 31-day grace period three years ago

C. The policy automatically converted to extended term insurance, and the term period is now expiring

D. The guaranteed interest rate expired, so the insurer is required by law to terminate the contract

**334. A universal life illustration shows Ken's cash value growing at the insurer's current declared rate of 5.5 percent, while the contract itself states a 2 percent minimum rate. Ken asks his producer which rate he can actually count on for the life of the policy. What is the accurate answer?**

A. The 5.5 percent rate, because an illustrated rate becomes contractually binding once the policy is delivered

B. The average of the two rates, because regulators require insurers to split the difference

C. Neither rate, because universal life interest crediting carries no guarantees of any kind

D. Only the 2 percent contractual minimum; the current rate can change at the insurer's discretion

**335. Dev reviews his universal life annual statement and sees that amounts were deducted from his account value every month, even in months when he paid no premium. These monthly deductions consist of what?**

A. Policy loan interest and federal income tax withholding

B. Surrender charges and state premium taxes

C. The cost of insurance charge plus the policy's expense charges

D. Dividend repayments and reinstatement fees

**336. When Sofia bought her universal life policy, the insurer calculated a 'target premium' for her to pay. Sofia wants to know what that figure actually promises. Which response is correct?**

A. It is the premium the state requires; paying it makes the coverage guaranteed to age 121

B. It is an estimate, based on current assumptions, of the level payment that should keep the policy in force; it is not a guarantee

C. It is the legal maximum she may pay into the policy in any year

D. It is the minimum deposit needed to avoid modified endowment contract status

**337. Lena owns a variable universal life policy and directed her entire cash value into stock subaccounts. The market falls sharply and her cash value drops 30 percent. Who bears this investment loss?**

A. Lena, because separate account values in a variable policy rise and fall with the investments she selected, with no guaranteed minimum cash value

B. The insurer, because state law requires the general account to restore any separate account losses

C. The subaccount fund managers, who must reimburse policyowners for negative returns

D. No one, because the loss is only on paper and the insurer must credit the guaranteed universal life interest rate instead

**338. Ray's indexed universal life policy credits interest based on an equity index, with a 0 percent floor and a 10 percent cap. This year the index declines 8 percent. What interest is credited to Ray's cash value for the year?**

A. Negative 8 percent, mirroring the index decline

B. 10 percent, because the cap applies in all years

C. Negative 10 percent, the worst outcome the cap permits

D. 0 percent, because the floor protects the account from index losses

**339. Carlos, age 30, tells his producer he wants a policy whose premium can never be raised, whose death benefit is guaranteed for his entire life, and whose cash value grows on a schedule guaranteed in the contract. Which policy meets all three requirements?**

A. Annual renewable term

B. Continuous-premium (straight) whole life

C. Universal life with the level death benefit option

D. Variable universal life

**340. Nadia, age 40, is comparing a 20-pay whole life policy with a continuous-premium whole life policy, each with a $250,000 face amount from the same insurer. Which statement accurately describes the 20-pay policy?**

A. Its annual premium is higher, its cash value grows faster, and no premiums are owed after 20 years, but the death benefit is the same $250,000

B. Its annual premium is lower because the insurer collects premiums for a shorter time

C. Its death benefit is larger to compensate for the shorter premium-paying period

D. Its coverage ends at the close of the 20-year premium period unless it is converted

**341. Hank, age 55, pays a single $120,000 premium for a whole life policy and asks about its characteristics. Which statement is accurate?**

A. The policy builds no cash value until the seventh policy year

B. The policy will pay dividends that are always received income tax free in unlimited amounts

C. The policy has substantial immediate cash value but is a modified endowment contract, changing how lifetime distributions are taxed

D. The policy avoids modified endowment status because only flexible-premium contracts can become MECs

**342. Jared, a 26-year-old resident physician who expects his income to rise sharply, wants permanent whole life coverage but can afford only a small premium today. Which whole life design is built for his situation?**

A. Single-premium whole life

B. 20-pay whole life

C. Current assumption universal life

D. Modified premium whole life, with a lower premium in the early years and a higher level premium thereafter

**343. Elaine borrowed against her $150,000 whole life policy and died with a $25,000 loan balance outstanding, including accrued interest. How much will her beneficiary collect?**

A. $150,000, because policy loans are forgiven at death

B. $125,000, the face amount reduced by the outstanding loan balance

C. $150,000 now, with the estate required to repay the $25,000 separately

D. Nothing until the loan is repaid by the beneficiary

**344. After a job loss, Marcus can no longer pay the premiums on his whole life policy, but he wants to keep some life insurance in force for the rest of his life without ever paying another premium. He does not need cash now. Which choice fits his goal?**

A. Surrender the policy for its net cash value

B. Elect the extended term nonforfeiture option

C. Elect the reduced paid-up nonforfeiture option

D. Take a maximum policy loan and let the policy lapse

**345. Alan's whole life policy states that its premiums, cash values, and death benefit are fixed at issue and that the policy is not eligible to receive any portion of the insurer's surplus. What kind of policy does Alan own?**

A. A nonparticipating policy

B. A participating policy

C. An assessable mutual policy

D. A variable whole life policy

**346. The Riveras have three children and add a children's term rider to the father's whole life policy. A fourth child is born two years later. How does the rider typically treat the new baby?**

A. The baby is excluded until the rider is rewritten and repriced with a medical exam

B. The baby must be covered under a separate, individually underwritten juvenile policy

C. Coverage applies only to children alive when the rider was issued

D. The baby is automatically covered under the same rider for the same single premium after a brief minimum age is reached

**347. Tara bought a 20-year level term policy with a return of premium rider. She is alive and the policy is still in force when the 20-year level term period ends. What does the rider provide?**

A. A paid-up whole life policy equal to the original face amount

B. A refund of all or a stated portion of the premiums she paid, since no death benefit was paid during the term

C. Nothing, because return of premium applies only if the insured dies during the term

D. The face amount, paid in installments over her remaining lifetime

**348. Gloria, age 78, is not terminally ill, but she can no longer bathe or dress without assistance and needs to pay for extended nursing home care. Which life insurance rider is designed to advance part of her death benefit for this situation?**

A. The accelerated death benefit (terminal illness) rider, because any serious condition qualifies

B. The waiver of premium rider

C. A long-term care or chronic illness rider, which pays when the insured cannot perform activities of daily living

D. The guaranteed insurability rider

**349. Dmitri worries that inflation will erode the purchasing power of his $200,000 life insurance death benefit over the coming decades. Which rider directly addresses this concern?**

A. A cost of living rider, which allows additional coverage tied to increases in a cost-of-living index

B. A return of premium rider, which refunds premiums at the end of the term

C. An accidental death benefit rider, which doubles the payout for accidental death

D. A payor benefit rider, which waives premiums if the premium payor dies

**350. A mother buys a whole life policy on her 8-year-old daughter and adds a payor benefit rider, naming herself as payor. The mother dies when the child is 12. What does the rider do?**

A. It pays the policy's face amount immediately to the child's guardian

B. It cancels the policy and refunds all premiums paid to the mother's estate

C. It waives the premiums on the child's policy, keeping it in force until the child reaches the age specified in the rider

D. It converts the juvenile policy into term insurance on the guardian's life

**351. Roberto owns a whole life policy with both a waiver of premium rider and a disability income rider. He becomes totally disabled and satisfies each rider's waiting period. How do the two riders respond differently?**

A. Both riders pay him identical monthly cash benefits

B. Waiver of premium keeps the policy in force without premium payments, while the disability income rider pays him a monthly income, typically limited to a percentage of the face amount

C. The disability income rider waives his premiums, while waiver of premium pays him monthly income

D. Both riders merely suspend the policy until he recovers, with no cash paid and no coverage in force

**352. Chloe, age 27 and newly licensed as an architect, can afford only modest coverage today but expects to need much more insurance as she marries and has children. She wants to lock in the right to buy that future coverage even if she later develops a serious illness. Which rider should her producer recommend?**

A. The guaranteed insurability rider, permitting additional purchases at specified dates or events with no new evidence of insurability

B. The accidental death benefit rider

C. The cost of living rider, which adjusts coverage only for inflation

D. The accelerated death benefit rider

**353. Arthur, a retiree on a fixed budget, owns a participating whole life policy and wants each year's dividend sent to him as spendable money he can deposit in his checking account. Which dividend option should he elect?**

A. Paid-up additions

B. Accumulate at interest

C. One-year term

D. The cash option

**354. Beth's participating whole life premium is $1,800 per year, and her insurer declares a $300 dividend. She elects the premium reduction dividend option. What happens at her next premium due date?**

A. The insurer applies the $300 against the premium due, and Beth pays the remaining $1,500 out of pocket

B. The insurer bills the full $1,800 and mails Beth a $300 check afterward

C. The insurer waives the entire $1,800 premium for the year

D. The $300 buys additional paid-up coverage and the full $1,800 remains payable

**355. For twenty years, Vera left her policy dividends with the insurer under the accumulate at interest option. She dies with $18,000 of accumulated dividends and interest on deposit, and her policy's face amount is $100,000. What does her beneficiary receive?**

A. $100,000, because accumulated dividends revert to the insurer at death

B. $118,000 - the face amount plus the accumulated dividends and interest

C. $100,000, with the $18,000 payable only to Vera's estate creditors

D. $82,000, because accumulations are subtracted from the face amount

**356. Omar was recently diagnosed with a heart condition that would make new life insurance unaffordable. He wants his participating whole life policy's death benefit to keep growing anyway. Why does the paid-up additions dividend option still work for him?**

A. Because the insurer must ignore health only if the policy is more than ten years old

B. Because paid-up additions are purchased from a guaranteed side fund rather than as insurance

C. Because each dividend buys a small block of paid-up permanent insurance at his attained age with no evidence of insurability required

D. Because the option converts the policy to one-year term coverage, which is never underwritten

**357. Wanda, whose children are still young, wants each year's policy dividend to buy the largest possible amount of additional death protection for that year, and she accepts that the extra coverage will expire annually. Which dividend option matches her goal?**

A. Accumulate at interest

B. Premium reduction

C. Paid-up additions

D. The one-year term (fifth dividend) option

**358. Frank has received $4,000 in cash dividends over the years on his participating whole life policy, on which he has paid $60,000 in total premiums. He asks his producer whether he owes federal income tax on the dividend checks. What is the correct answer?**

A. Yes - policy dividends are taxed as ordinary income in the year received

B. No - the dividends are a return of premium and are not taxable because they do not exceed the premiums he has paid

C. Yes, but only at capital gains rates

D. No, but he must repay the dividends if he ever surrenders the policy

**359. Iris elects the accumulate at interest dividend option. This year the insurer credits her a $500 dividend and $120 of interest on her accumulated dividend deposits. What must Iris report as taxable income for the year?**

A. The $120 of interest only

B. The full $620

C. The $500 dividend only

D. Nothing, because all funds remain inside a life insurance contract

**360. Over many years, Sylvia has paid $30,000 in total premiums on her participating whole life policy and has taken every dividend in cash. This year's $3,000 dividend brings her cumulative dividends to $32,000. How is this year's dividend taxed?**

A. The entire $3,000 is tax free, because policy dividends are never taxable

B. The entire $3,000 is taxable as ordinary income

C. $2,000 is taxable - the amount by which cumulative dividends now exceed her total premiums paid

D. $1,000 is taxable, because one-third of any dividend is deemed interest

**361. A worker dies fully insured, survived by a spouse age 42 and one child age 14. The spouse receives Social Security survivor benefits while caring for the child. The spouse's own child-in-care benefit will generally stop, beginning the family's 'blackout period,' when what occurs?**

A. The child graduates from high school
B. The child reaches age 16
C. The child reaches age 18
D. The spouse reaches full retirement age

**362. A fully insured worker dies. Her husband was living in the same household with her at the time of death. What one-time payment can he receive from Social Security in addition to any monthly survivor benefits?**

A. A lump-sum death payment of up to $255
B. A lump-sum death payment equal to one year of the worker's benefit
C. A funeral allowance equal to the worker's final salary
D. No lump-sum payment; Social Security pays only monthly benefits

**363. A 28-year-old worker dies after earning 10 quarters of coverage in total, 6 of them during the 13-quarter period ending with the quarter of death. For Social Security survivor purposes, this worker died with which insured status?**

A. Fully insured, because any quarters at all are enough before age 30
B. Uninsured, because 40 quarters are always required
C. Disability insured only
D. Currently insured, so certain survivor benefits such as the lump-sum death payment and benefits for eligible children are still payable

**364. A deceased worker was fully insured. Which of the worker's surviving children is generally eligible for Social Security child's survivor benefits?**

A. A 20-year-old attending college full time
B. An 18-year-old attending high school full time
C. A 19-year-old who works full time
D. A healthy 25-year-old who lived in the worker's home

**365. While preparing a needs analysis for a young family, a producer subtracts the Social Security survivor benefits the family would receive from the monthly income the family would need. Why?**

A. Social Security benefits are assignable to the insurer
B. Federal law requires the deduction before life insurance may be sold
C. Survivor benefits replace part of the lost income, so less life insurance is needed to fill the remaining gap
D. The deduction increases the death benefit the family will receive

**366. A widow age 52 has been unable to work for two years because of a disability. She applies for survivor benefits on her deceased husband's fully insured record. Which statement is accurate?**

A. She may qualify now, because a disabled widow can be eligible as early as age 50
B. She must wait until age 60 regardless of her disability
C. She must wait until her own full retirement age
D. Widows qualify at any age even without a disability

**367. Four 65-year-olds annuitize identical accumulated values on the same date. Based on the guarantees involved, which election produces the SMALLEST monthly payment?**

A. Life only
B. Life with 10-year period certain
C. Cash refund
D. Joint and 100 percent survivor covering the annuitant and a same-age spouse

**368. A 70-year-old deferred annuity owner wants regular monthly income but refuses any arrangement that permanently gives up access to her remaining contract value. Which approach fits her goal?**

A. Annuitizing under a life-only option
B. Annuitizing under a joint and survivor option
C. Taking systematic withdrawals from the contract

D. Exchanging the annuity for an immediate annuity

**369. A retiree annuitizes a nonqualified annuity with an investment in the contract of $60,000 and an expected return of $150,000, producing payments of $1,000 per month. How much of each payment is excluded from gross income?**

A. $1,000
B. $400
C. $600
D. $0

**370. The owner of a nonqualified deferred annuity with a large gain asks to exchange it directly for a whole life insurance policy. What is the federal tax result?**

A. The exchange does not qualify under Section 1035, so the gain is taxable
B. The exchange is tax-free because both are insurance products
C. The exchange is tax-free if both contracts are with the same insurer
D. The exchange is tax-free if completed within 60 days

**371. Two retirees each receive $2,000 per month from annuities. One annuity was purchased entirely with pre-tax dollars inside a traditional IRA; the other was purchased with after-tax personal savings. How do the payments differ for federal income tax purposes?**

A. Both payments are entirely tax-free
B. Both payments are entirely taxable
C. The IRA-funded payments are fully taxable, while the nonqualified payments are taxable only to the extent they represent earnings
D. The nonqualified payments are fully taxable, while the IRA-funded payments are tax-free

**372. A 47-year-old surrenders a nonqualified deferred annuity that has substantial gain. No exception applies. In addition to ordinary income tax on the gain, what does federal law impose?**

A. A capital gains surcharge
B. Forfeiture of the entire gain
C. Nothing further; only ordinary income tax applies
D. An additional tax equal to 10 percent of the taxable portion of the distribution

**373. A fixed annuity includes a market value adjustment (MVA). Market interest rates are now significantly HIGHER than when the owner purchased the contract. If the owner takes a large withdrawal during the adjustment period, what is the typical effect of the MVA?**

A. It reduces the amount the owner receives
B. It increases the amount the owner receives
C. It has no effect on withdrawals, only on annuitized payments
D. It converts the withdrawal into a tax-free exchange

**374. A 72-year-old uses part of her traditional IRA to purchase a qualifying longevity annuity contract (QLAC). Which statement correctly describes the RMD treatment?**

A. The QLAC has no effect on required minimum distributions
B. Prior to annuitization, the QLAC's value is excluded from the balance used to compute her required minimum distributions, and its payments must begin no later than the month after she turns 85
C. The QLAC doubles her required minimum distributions
D. QLACs may only be purchased inside Roth IRAs

**375. A producer estimates a client's life insurance amount by projecting the client's earnings until retirement, subtracting the cost of the client's own self-maintenance, and discounting the result to present value. Which method is the producer using?**

A. The needs approach
B. The capital gains approach
C. The human life value approach
D. The buy-term-and-invest-the-difference approach

**376. An applicant wonders how an insurer can promise a $500,000 death benefit in exchange for a relatively small annual premium. What insurance mechanism makes this possible?**

A. Pooling a large number of similar risks so that the losses of the few are spread across the premiums of the many

B. Investing each policyholder's premium until it individually grows to $500,000

C. Reinsuring every policy with the federal government

D. Charging surviving policyholders an assessment after each death claim

**377. A 30-year-old parent wants the largest possible death benefit for the lowest current outlay to protect her family until the children are grown, and she has no interest in accumulating cash value. Which policy best fits?**

A. Whole life

B. A single-premium endowment

C. Variable universal life

D. Level term insurance for a 20-year period

**378. Two business partners buy life insurance on each other to fund a buy-sell agreement. Years later the partnership is dissolved, but one former partner keeps the policy in force and the insured then dies. May the insurer refuse the claim for lack of insurable interest?**

A. Yes, because insurable interest must exist at the time of death

B. No, because insurable interest is required only when the policy is issued, and it existed then

C. Yes, unless the insured's family consents to payment

D. No, because business policies never require insurable interest

**379. An insurer wants to rely on an applicant's written answers to contest a life insurance claim. Under the standard entire-contract provision, what generally must be true for those answers to be part of the legal contract?**

A. The agent must have witnessed the applicant's signature

B. The answers must have been given under oath

C. A copy of the application must be endorsed on or attached to the policy when it is issued

D. The answers must be notarized within 30 days of delivery

**380. An applicant pays the first premium with his application and receives a conditional receipt. He dies ten days later, before the policy is issued. Underwriting shows he was insurable as a standard risk on the application date. What is the likely result?**

A. The death benefit is payable, because coverage became effective when the receipt's insurability condition was satisfied

B. Only the premium is refunded, because no policy was ever delivered

C. Nothing is payable, because conditional receipts never provide coverage before issue

D. Half the face amount is payable as a compromise settlement

**381. Four workers each want to make salary-deferral contributions to a 403(b) tax-sheltered annuity through their employer. Who is eligible?**

A. A marketing manager at a for-profit software company

B. A teacher employed by a public high school

C. A self-employed retail store owner

D. A loan officer at a commercial bank

**382. A firm with 40 employees already maintains a 401(k) plan and asks a producer about adding a SIMPLE IRA plan for the same workforce. What should the producer explain?**

A. It may add the SIMPLE plan as long as total contributions stay within limits

B. It may add the SIMPLE plan only if it freezes 401(k) matching

C. SIMPLE plans are available only to employers with more than 100 employees

D. It generally cannot adopt a SIMPLE plan, because an employer with a SIMPLE IRA cannot maintain another retirement plan

**383. A 30-year-old in a modest tax bracket wants her retirement account distributions to come out completely tax-free and is willing to give up any current-year deduction to get that result. Which arrangement fits?**

A. A Roth IRA, funded with after-tax contributions

B. A traditional IRA, funded with deductible contributions

C. A nonqualified deferred annuity

D. A SEP IRA funded by her employer

**384. An employee complains that his private-sector employer offers no pension plan and insists that federal law requires one. Regarding ERISA, what is the accurate response?**

A. ERISA requires every employer with 10 or more workers to fund a pension

B. ERISA guarantees each worker a benefit equal to final salary

C. ERISA does not require an employer to establish a plan; it sets minimum participation, vesting, accrual, and funding standards and fiduciary duties for plans that are voluntarily established

D. ERISA applies only to government and church plans

**385. A plan participant receives an eligible rollover distribution by check on June 1 and deposits the full amount into an IRA on August 20 of the same year. No IRS waiver applies. What is the federal tax result?**

A. The rollover is valid because it was completed in the same tax year

B. The rollover is valid because IRAs have no time limit

C. Only half of the deposit is treated as a rollover

D. The distribution is taxable, because a rollover must be completed by the 60th day after the day the funds are received

**386. A 78-year-old policyowner no longer needs her life insurance and decides to sell it in a life settlement rather than surrender it. To whom is the policy properly sold?**

A. Directly back to the issuing insurer at face value

B. A life settlement provider licensed with the state insurance regulator, which may hold the policy or resell it to institutional investors

C. Her insurance producer personally

D. The policy's named beneficiary

**387. An insured who has been diagnosed as terminally ill sells his life insurance policy to a third party for a discounted lump sum based on his shortened life expectancy. This transaction is best described as what?**

A. A viatical settlement

B. An accelerated death benefit claim paid by the insurer

C. A Section 1035 exchange

D. A policy loan

**388. A policyowner comparing options is offered a life settlement on her $500,000 policy, which has a $40,000 cash surrender value. Where should a legitimate life settlement offer generally fall?**

A. Below the cash surrender value

B. Exactly equal to the death benefit

C. More than the $40,000 cash surrender value but less than the $500,000 death benefit

D. Exactly equal to the total premiums she has paid

**389. Before signing a life settlement contract, what should the insured understand about his medical information?**

A. Federal law bars the buyer from ever seeing his medical records

B. Only the original insurer may review his health history

C. His records are sealed once the policy is sold

D. The buyer may obtain his health information and share it with other entities, such as lenders or third-party investors, and may track his health status going forward

**390. An insured completes a life settlement on his $300,000 policy. His daughter had been the named beneficiary for twenty years. When the insured later dies, who collects the death benefit?**

A. The daughter, because a beneficiary designation survives any sale

B. The settlement provider or its investors, who became the policy's owner and beneficiary and paid the premiums after the sale

C. The insured's estate

D. The insurer keeps it, because settled policies are void at death

**391. An applicant completes a life insurance application with detailed health questions but is not required to take a medical exam. The insurer underwrites from the application, prescription histories, and database checks. Which underwriting approach is this?**

A. Guaranteed issue

B. Simplified issue

C. Full (traditional) underwriting

D. Post-claim underwriting

**392. A 68-year-old with serious health problems buys a small whole life policy that asked no health questions and required no exam - acceptance was automatic within the eligible age range. What kind of policy is this?**

A. A guaranteed issue policy

B. A preferred risk policy

C. A simplified issue policy

D. A group conversion policy

**393. A guaranteed issue policy has a two-year graded death benefit. The insured dies of natural causes 14 months after issue. What does the beneficiary typically receive?**

A. Nothing, because the policy was not yet in force

B. The full face amount

C. A refund of the premiums paid, often plus interest

D. Only the policy's cash surrender value

**394. A healthy 30-year-old applies online and receives a fully underwritten decision in days, with no exam, after the insurer's program analyzes her application against prescription, MIB, and motor vehicle records. Which underwriting approach is this?**

A. Guaranteed issue

B. Postmortem underwriting

C. Group underwriting

D. Accelerated underwriting

**395. As part of full underwriting, a technician visits an applicant to record medical history, measure height, weight, and blood pressure, and collect blood and urine samples. What is this called?**

A. A paramedical exam

B. An attending physician statement

C. An inspection report

D. A Medical Information Bureau screening

**396. A healthy 35-year-old wants $500,000 of term coverage at the lowest cost and doesn't mind an exam. A producer comparing fully underwritten coverage against guaranteed issue should explain that:**

A. Guaranteed issue will be cheaper because it skips the exam

B. Both cost the same by law

C. Guaranteed issue is not designed for this need - it offers small face amounts at high cost, priced for applicants who cannot pass underwriting

D. Fully underwritten coverage is only for applicants over 60

# National - Health Insurance (300 questions)

**397. What is the primary purpose of health insurance?**

A. To build tax-deferred cash value for retirement
B. To pay for or reimburse medical expenses
C. To indemnify the insured for damage to property
D. To provide a death benefit to named beneficiaries

**398. What is a 'deductible' in health insurance?**

A. The maximum amount the insurer will pay for covered expenses in a policy year
B. The percentage of covered expenses the insured shares with the insurer after the deductible
C. The amount the insured must pay before insurance begins covering expenses
D. The fixed dollar amount the insured pays each time a covered service is received

**399. What is 'coinsurance' in health insurance?**

A. The fixed dollar amount the insured pays at the time a covered service is received
B. The amount the insured must pay each year before the plan begins paying benefits
C. The rule deciding which plan pays first when the insured is covered by two plans
D. The percentage of costs the insured pays after the deductible is met

**400. What is a 'copayment' (copay)?**

A. A fixed amount paid for a covered service at the time of service
B. A percentage of the bill the insured pays after the deductible is met
C. The amount the insured pays each year before the plan starts to pay
D. The periodic amount paid to the insurer to keep the policy in force

**401. What is the 'out-of-pocket maximum' in health insurance?**

A. The highest deductible a plan may charge before it must begin sharing your costs
B. The most you have to pay for covered services in a year before insurance pays 100%
C. The most the insurance company will pay for your covered services during the year
D. The total premium you can be charged for coverage during a single policy year

**402. What is a 'pre-existing condition'?**

A. A condition that first appears during the probationary period
B. A chronic condition that is not covered under any health plan
C. A health condition that existed before coverage began
D. A medical exam the insurer requires before issuing a policy

**403. What does 'network' mean in health insurance?**

A. The group of insurers that share a large risk under a reinsurance treaty
B. The list of prescription drugs a health plan agrees to cover
C. The producers and agencies appointed to sell a health plan's policies
D. The facilities, providers, and suppliers a health plan contracts with

**404. What is 'prior authorization' in health insurance?**

A. Approval from the insurer before receiving certain services or medications
B. An insurer review conducted after treatment to decide whether it was medically necessary
C. The insured's written consent allowing the insurer to obtain medical records
D. Evidence of prior creditable coverage submitted when applying for a new policy

**405. What is an HMO (Health Maintenance Organization)?**

A. A managed care plan that lets members see any provider without a referral, paying more out of network
B. A managed care plan requiring members to use network providers and select a PCP
C. A federal program that pays hospital and physician bills for people age 65 and older
D. A self-funded plan in which the employer pays claims directly instead of buying insurance

**406. What is a PPO (Preferred Provider Organization)?**

A. A plan that requires a primary care physician referral before any specialist visit
B. A plan that pays for out-of-network care in an emergency but not otherwise
C. A plan that offers more flexibility to see in-network or out-of-network providers
D. A plan that pays a fixed daily benefit directly to the insured during a hospital stay

**407. What is an EPO (Exclusive Provider Organization)?**

A. A plan that pays a reduced benefit for care received outside the network
B. A plan that requires a PCP referral before covering a specialist visit
C. A plan that lets members use any provider at the same cost-sharing level
D. A plan that only covers in-network care except in emergencies

**408. What is an HDHP (High Deductible Health Plan)?**

A. A plan with higher deductibles and lower premiums, often paired with an HSA
B. A plan with higher premiums and lower deductibles, usually paired with an FSA
C. A plan that covers hospital charges after a large per-admission deductible is met
D. A plan whose deductible is reset each time a new covered illness or injury begins

**409. What is a POS (Point of Service) plan?**

A. A plan that reimburses any provider the member chooses on a fee-for-service basis
B. A plan combining HMO and PPO features with a PCP who can refer out of network
C. A plan that restricts coverage to network providers but does not require referrals
D. A plan that combines a high deductible with a tax-favored health savings account

**410. What is 'major medical' insurance?**

A. Basic hospital, surgical, and medical coverage with low limits, first-dollar benefits, and no deductible
B. Coverage that pays a scheduled cash benefit for each day the insured is confined to a hospital
C. Comprehensive coverage for a wide range of healthcare expenses, subject to an out-of-pocket maximum
D. Coverage limited to catastrophic illnesses such as cancer, stroke, or heart attack, paid as a lump sum

**411. What is a 'Health Savings Account' (HSA)?**

A. An employer-owned account funded solely by the employer to reimburse medical costs
B. An employer account whose unused balance is forfeited at the end of the plan year
C. A savings account available to people enrolled in a PPO plan rather than an HDHP
D. A tax-advantaged account for medical expenses, paired with an HDHP

**412. What is a 'Flexible Spending Account' (FSA)?**

A. An employer-sponsored account for pre-tax medical expense savings with use-it-or-lose-it rules
B. A portable, individually owned account whose unused balance rolls over from year to year
C. An employer-funded reimbursement arrangement that employees cannot contribute to themselves
D. An account for medical expenses that can be opened by someone enrolled in a high deductible health plan

**413. What is the 'elimination period' in health/disability insurance?**

A. The period after issue during which sickness claims are not covered
B. The waiting period before benefits begin after a covered event
C. The period after a missed premium during which coverage stays in force
D. The maximum length of time benefits are paid for a single disability

**414. What is 'coordination of benefits' (COB)?**

A. Rules requiring the insurer to be reimbursed by a third party who caused the loss
B. Rules requiring an employer and employees to share the cost of group premiums
C. Rules determining payment responsibility when the insured has multiple health plans
D. Rules allowing the insurer to reduce benefits when the insured's earnings have changed

**415. What is the 'benefit period' in health insurance?**

A. The time the insured must wait after a loss before benefits are paid
B. The time after issue during which sickness is not covered
C. The time after a premium due date during which coverage continues

D. The time during which benefits are provided for a covered event

**416. What is a 'guaranteed renewable' policy?**

A. A policy the insurer must renew regardless of health changes
B. A policy the insurer may cancel at any time by returning unearned premium
C. A policy whose premium is locked in and cannot be raised by the insurer
D. A policy the insurer may decline to renew for reasons stated in the contract

**417. What does 'noncancelable' mean in health insurance?**

A. The insurer must renew the policy but may raise premiums for an entire class
B. The insurer cannot cancel or raise premiums as long as premiums are paid
C. The insurer may cancel mid-term as long as it refunds the unearned premium
D. The insured is locked into the contract and cannot drop coverage before it expires

**418. What is 'subrogation' in health insurance?**

A. The insurer's right to reduce benefits when the insured is covered under another plan
B. The insured's right to transfer ownership of the policy to another person or entity
C. The insurer's right to recover claim payments from a third party responsible for the loss
D. The insurer's right to examine the insured at its own expense while a claim is pending

**419. What is the purpose of disability insurance?**

A. To pay hospital and physician bills when the insured is sick or injured
B. To pay a lump sum to beneficiaries if the insured dies from an accident
C. To cover the cost of custodial and nursing home care for the insured
D. To replace income when the insured cannot work due to illness or injury

**420. What is 'own occupation' disability?**

A. Inability to perform the duties of your specific occupation
B. Inability to perform the duties of any job suited to your training
C. Inability to earn at least a set percentage of your prior income
D. Inability to perform basic activities of daily living without help

**421. What is 'any occupation' disability?**

A. Inability to find work in any available job
B. Inability to perform any occupation for which the insured is reasonably suited by education, training, or experience
C. Coverage for any type of work
D. Multiple occupation coverage

**422. What is 'short-term disability' insurance?**

A. Coverage that replaces income for an extended period, often until age 65
B. Coverage that pays medical bills for minor injuries that heal within a few weeks
C. Coverage that replaces income for a limited period, typically 3-6 months
D. Coverage that pays partial benefits when the insured returns to work at reduced pay

**423. What is 'long-term disability' insurance?**

A. Coverage that pays for nursing home or custodial care for the rest of the insured's life
B. Coverage that replaces income for a limited period, typically a few months
C. Coverage that pays hospital and doctor bills for chronic conditions over many years
D. Coverage that provides income for extended periods, often until age 65

**424. What is 'residual disability' coverage?**

A. Partial benefits when the insured can work but at reduced capacity or income
B. Full benefits that continue after the insured recovers and returns to work full time
C. Benefits for a disability that recurs after the insured has returned to work
D. Benefits payable for the portion of the elimination period the insured has completed

**425. What is Medicare?**

A. Joint federal-state program for people with limited income and assets
B. Federal health insurance program primarily for people 65 and older
C. State-administered program that pays for work-related injuries and illness
D. Private supplemental insurance that pays deductibles and coinsurance

**426. What does Medicare Part A cover?**

A. Medical insurance for doctor visits and outpatient care
B. Outpatient prescription drug coverage
C. Hospital insurance including inpatient care
D. Routine dental, vision, and hearing services

**427. What does Medicare Part B cover?**

A. Hospital insurance including inpatient stays and skilled nursing care
B. Prescription drug coverage sold through private plans
C. Custodial long-term nursing home care for the elderly
D. Medical insurance including doctor services and outpatient care

**428. What is Medicare Part C (Medicare Advantage)?**

A. Private supplemental policies that pay Original Medicare's deductibles, copays, and coinsurance
B. Private health plans that provide all Part A and B coverage, often with additional benefits
C. Stand-alone prescription drug plans sold by private insurers approved by Medicare
D. Government-run plans that replace Parts A and B for people who are still working at 65

**429. What does Medicare Part D cover?**

A. Prescription drug coverage
B. Inpatient hospital care
C. Outpatient physician services
D. Routine dental and vision care

**430. What is a Medicare Supplement (Medigap) policy?**

A. A private plan that replaces Original Medicare to deliver Part A and B benefits
B. A state program that pays Medicare premiums for people with limited income
C. Private insurance that helps pay Medicare's gaps like deductibles and coinsurance
D. A private drug plan that fills the coverage gap in Medicare's Part D benefit

**431. What is Medicaid?**

A. A federal program providing hospital and medical coverage to people age 65 and older
B. A private supplemental policy that pays the deductibles Medicare does not cover
C. A federal marketplace where individuals buy subsidized private health plans
D. A joint federal-state program providing health coverage to low-income individuals

**432. Can someone be eligible for both Medicare and Medicaid?**

A. Yes, these individuals are called 'dual eligibles'
B. No, enrolling in Medicare automatically ends Medicaid eligibility
C. Yes, but the person must give up Medicare Part B to keep Medicaid
D. Yes, but Medicaid then pays none of Medicare's cost sharing

**433. What is group health insurance?**

A. Health coverage sold to individuals who share a common hobby or interest
B. Health coverage provided to a group, typically by an employer
C. Individual policies issued to each employee with separate underwriting
D. Health coverage formed by a group of insurers pooling a single large risk

**434. What is COBRA?**

A. A law requiring group plans to cover pre-existing conditions after a waiting period
B. A law giving employees the right to convert group coverage to an individual policy
C. A law allowing continued group health coverage after qualifying events like job loss

D. A federal program that pays premiums for workers who lose employer coverage

**435. How long can COBRA coverage typically last?**

A. 36 months for most qualifying events
B. 12 months for most qualifying events
C. 29 months for most qualifying events
D. 18 months for most qualifying events

**436. Who pays for COBRA coverage?**

A. The former employee pays the full premium plus up to a 2% administrative fee
B. The plan's insurer absorbs the cost until the employee finds new coverage
C. The former employer pays the full premium for the first 18 months
D. The employee pays the same share he or she paid while actively employed

**437. What companies must offer COBRA?**

A. All companies regardless of size
B. Employers with 20 or more employees
C. Only government employers
D. Only Fortune 500 companies

**438. What is the Affordable Care Act (ACA)?**

A. Federal law that lets workers continue group coverage after leaving a job
B. Federal law that created Medicare and Medicaid for seniors and the poor
C. Federal law that reformed health insurance and expanded coverage access
D. Federal law that protects the privacy and portability of health information

**439. What are the 'essential health benefits' under the ACA?**

A. Services that Medicare Advantage plans must add beyond Parts A and B
B. Benefits an insurer may offer as optional riders for an extra premium
C. Emergency and hospital services that every short-term plan must include
D. Ten categories of services ACA marketplace plans must cover

**440. What is a 'health insurance marketplace' (exchange)?**

A. A platform where individuals can shop for and purchase ACA-compliant health plans
B. A private exchange where employers buy stop-loss coverage for self-funded plans
C. A federal agency that sets the premium rates insurers may charge for health plans
D. A network of hospitals and clinics that agree to accept marketplace plan members

**441. What are 'premium tax credits' under the ACA?**

A. Deductions employers claim for the premiums they pay on behalf of workers
B. Subsidies to help eligible individuals afford marketplace health insurance
C. Reductions in deductibles and copays for eligible members who choose a silver plan
D. Refunds insurers must pay when they spend too little of premiums on care

**442. What is 'guaranteed issue' under the ACA?**

A. Insurers must renew coverage each year unless the insured stops paying premiums
B. Insurers must charge every applicant the same premium regardless of age or tobacco use
C. Insurers must accept all applicants regardless of health status or pre-existing conditions
D. Insurers must cover a pre-existing condition after a waiting period of no more than a year

**443. What is the ACA's 'open enrollment period'?**

A. The window after a qualifying life event when someone may enroll outside the normal season
B. The period each fall when Medicare beneficiaries may switch Advantage or drug plans
C. The first months after issue during which a plan may exclude pre-existing conditions
D. The annual period when individuals can enroll in or change marketplace plans

**444. What is a 'special enrollment period' (SEP)?**

A. A time outside open enrollment when someone can enroll due to a qualifying life event
B. A time each fall when anyone can enroll in or change a marketplace plan for the next year
C. A seven-month window around a person's 65th birthday for signing up for Medicare
D. A period during which a new employee must wait before group coverage takes effect

**445. What is HIPAA?**

A. Federal law creating the Health Insurance Marketplace and premium tax credits
B. Federal law protecting health information privacy and insurance portability
C. Federal law allowing employees to continue group health coverage after leaving a job
D. Federal law requiring parity between mental health and medical benefits

**446. What are 'unfair trade practices' in health insurance?**

A. Rating practices that charge higher premiums to groups with poor claims experience
B. Underwriting practices that classify applicants by legitimate risk factors such as age
C. Illegal or unethical business practices prohibited by insurance regulations
D. Competitive practices such as offering lower premiums than rival insurers in the state

**447. What is 'unfair discrimination' in insurance?**

A. Charging different rates based on legitimate risk factors
B. Charging lower premiums than competing insurers
C. Offering different policy types
D. Treating similarly situated individuals differently based on prohibited factors

**448. What is an agent's ethical duty of care when recommending coverage to a client?**

A. An ethical obligation to recommend coverage that suits the client's needs
B. A fiduciary duty to hold the client's premium payments in a separate trust account
C. A legal obligation to recommend the policy that produces the highest commission
D. An obligation to recommend the plan with the broadest benefits regardless of cost

**449. What is a 'formulary' in health insurance?**

A. A schedule of usual and customary charges for covered services
B. A list of network providers a member may use for care
C. A list of prescription drugs covered by a health plan
D. A list of pre-existing conditions excluded from a health plan

**450. What is 'step therapy' in prescription drug coverage?**

A. Requiring plan approval before a specialty drug is dispensed
B. Limiting the quantity of a drug a member may fill in a given period
C. Charging progressively higher copayments as drugs move up formulary tiers
D. Requiring trial of lower-cost drugs before more expensive options

**451. What is 'long-term care' insurance?**

A. Coverage for assistance with daily living activities when unable to care for oneself
B. Coverage that replaces lost income when a disability keeps the insured from working
C. Coverage for extended inpatient hospital stays beyond major medical benefit limits
D. Coverage that pays the gaps left by Medicare for physician and hospital deductibles

**452. What are 'activities of daily living' (ADLs)?**

A. Household tasks such as shopping and managing money and medications
B. Basic self-care tasks used to measure need for long-term care
C. Skilled nursing services ordered by a physician for a chronic condition
D. Cognitive tests used to diagnose dementia before benefits are paid

**453. What is a 'benefit trigger' in long-term care insurance?**

A. The waiting period that must pass before benefits begin
B. The event that causes premiums to be waived during a claim
C. The criteria that must be met before benefits are paid

D. The maximum number of days for which benefits will be paid

**454. What is 'mental health parity'?**

A. Requiring every health plan to offer mental health benefits as a covered service
B. Requiring equal premium rates for members with and without a mental health diagnosis
C. Requiring mental health screening before a policy is issued to an applicant
D. Requiring equal coverage for mental health as for medical/surgical conditions

**455. What is 'community rating' in health insurance?**

A. Setting premiums based on the entire community rather than individual health status
B. Setting premiums based on each applicant's individual medical history
C. Insurance for community organizations
D. Setting premiums based on a group's actual claims history

**456. What is 'experience rating' in health insurance?**

A. Setting premiums based on the average risk of a whole geographic area
B. Setting premiums based on a group's actual claims history
C. Setting premiums based on each member's individual medical exam
D. Setting premiums based on how long the group has been insured

**457. What is a 'gatekeeper' in managed care?**

A. A primary care physician who coordinates and authorizes specialist care
B. A utilization review nurse who approves hospital admissions in advance
C. A claims examiner who decides whether a submitted bill is a covered expense
D. A specialist who must approve the member's choice of primary care physician

**458. A prescription drug plan will cover no more than 30 tablets of a sleep medication per 30 days. Which utilization-management tool is the plan using?**

A. Step therapy
B. A formulary exclusion
C. Prior authorization
D. A quantity limit

**459. Why do many health plans encourage members to fill long-term maintenance medications through the plan's mail-order pharmacy?**

A. Mail-order drugs are exempt from the formulary
B. Mail order is the only way to obtain brand-name drugs
C. It removes the deductible from all other benefits
D. A 90-day supply by mail often costs the member less per dose than monthly retail fills

**460. For Medicare Part D purposes, what does 'creditable coverage' mean?**

A. Prior health coverage that shortens a pre-existing condition exclusion period under a new group plan
B. Prescription drug coverage that pays the beneficiary's Part D premiums and deductible in full
C. Prescription drug coverage that pays less than standard Part D but exempts the beneficiary from the late penalty
D. Prescription drug coverage expected to pay, on average, at least as much as standard Medicare Part D

**461. What is a 'high-risk pool'?**

A. State programs providing health insurance to individuals unable to obtain coverage elsewhere
B. Federal programs providing health insurance to low-income families with dependent children
C. Insurer-funded pools that pay the claims of a member company that becomes insolvent
D. Reinsurance arrangements spreading an insurer's largest health claims among other carriers

**462. What is 'CHIP' in health insurance?**

A. Catastrophic Hospital Indemnity Plan paying a fixed daily benefit for inpatient stays
B. Children's Health Insurance Program providing coverage for uninsured children
C. A federal program providing prescription drug coverage to children enrolled in Medicare
D. A federal-state program providing health coverage to disabled adults with low incomes

**463. What is 'adverse selection' in health insurance?**

A. The tendency for insured individuals to use more care because they do not bear its full cost
B. The practice of insurers declining applicants whose risk exceeds underwriting limits
C. The tendency for higher-risk individuals to seek more insurance coverage
D. The tendency for lower-risk individuals to purchase more coverage than they need

**464. What is 'moral hazard' in health insurance?**

A. The tendency for people in poor health to buy more coverage than healthy people
B. A physical condition of the insured that increases the chance of loss
C. The insurer's practice of denying claims it believes were not medically necessary
D. The tendency to use more services because insurance covers them

**465. During underwriting of an individual health application, the insurer asks the applicant's own doctor for a report on her medical history and treatment. What is this report called?**

A. A Medical Information Bureau (MIB) report
B. An inspection report
C. An attending physician statement (APS)
D. An agent's certification

**466. An applicant with well-controlled type 2 diabetes is offered an individual disability income policy at a premium 50% higher than standard. How is this underwriting outcome described?**

A. The policy was issued on a rated (substandard) basis
B. The applicant was declined
C. The policy includes an impairment exclusion rider
D. The applicant received a preferred classification

**467. Marketplace health plans are labeled Bronze, Silver, Gold, or Platinum. What do these metal levels actually indicate?**

A. The quality of the doctors in the plan's network
B. The average share of covered medical costs the plan pays
C. How large the insurance company is
D. How quickly the plan processes claims

**468. What is 'guaranteed renewability'?**

A. The insurer must renew coverage and may not raise the premium at renewal
B. The insurer must accept any new applicant regardless of health status
C. The insurer may decline renewal if the insured's health has declined
D. The insurer must renew coverage as long as premiums are paid

**469. What is 'rescission' in health insurance?**

A. Retroactive cancellation of coverage due to fraud or intentional misrepresentation
B. Renewal of the policy at its anniversary on the same terms
C. Prospective termination of coverage for nonpayment of premium
D. Reduction of benefits for a misstatement of age on the application

**470. What is a 'summary of benefits and coverage' (SBC)?**

A. A statement sent after each claim showing what the plan paid and what the member owes
B. A standardized document explaining what a health plan covers in plain language
C. A certificate given to group members as evidence of coverage under the master policy
D. A notice describing how a plan may use and disclose a member's health information

**471. What is 'medical loss ratio' (MLR)?**

A. The percentage of covered charges the insured must pay after satisfying the deductible
B. The percentage of premiums an insurer may retain for administrative costs and profit
C. The percentage of premiums an insurer must spend on medical care and quality improvement
D. The percentage of a hospital's charges that the plan agrees to pay under its network contract

**472. What is a 'qualified health plan' (QHP)?**

A. A plan that qualifies an insured to contribute to a health savings account
B. A private plan approved by Medicare to replace Original Medicare
C. An employer plan that meets ERISA fiduciary and reporting rules
D. A plan certified by the Marketplace meeting ACA standards

**473. Under the ACA, how are recommended in-network preventive services - such as immunizations and many screenings - covered?**

A. At 100%, with no copayment, coinsurance, or deductible
B. Only after the annual deductible is met
C. At 50% coinsurance
D. Only for children under age 18

**474. A married 24-year-old with a full-time job wants to stay on his mother's employer health plan. Does the ACA allow it?**

A. No - dependent coverage ends when the child marries
B. No - it ends when the child becomes employed
C. Yes - plans offering dependent coverage must cover adult children to age 26 regardless of marriage, student status, or employment
D. Yes, but only if he remains a full-time student

**475. What is 'cost-sharing reduction' (CSR)?**

A. Subsidies that lower the monthly premium for eligible people buying Marketplace coverage
B. Provisions that let family members combine their deductibles under a single family limit
C. Subsidies that lower deductibles, copays, and out-of-pocket limits for eligible individuals
D. Negotiated discounts that reduce what a plan pays hospitals for covered inpatient services

**476. Who is generally allowed to buy a catastrophic plan on the health insurance marketplace?**

A. Anyone willing to pay a higher premium
B. People under age 30, or those with a hardship or affordability exemption
C. Only people over age 55
D. Small business owners only

**477. In a typical HMO plan, what is the main role of a primary care physician?**

A. To act as the member's main doctor and coordinate care within the network
B. To provide specialty treatment after the member obtains a referral from the plan
C. To review submitted claims and decide which charges are medically necessary
D. To treat the member for any condition outside the network at no added cost

**478. Which statement best describes a PPO?**

A. It requires members to select a primary care gatekeeper for referrals
B. It usually gives members more provider flexibility than an HMO
C. It generally pays nothing for care from an out-of-network provider
D. It pays providers a fixed monthly capitation fee per enrolled member

**479. A member in a gatekeeper-style HMO wants to see a specialist. What is commonly required first?**

A. Preauthorization from the state insurance department
B. Payment of the annual deductible in full
C. A referral from the primary care physician
D. A second opinion from an out-of-network doctor

**480. Why do PPO plans often charge less when a member uses an in-network provider?**

A. The state requires in-network care to be free of any deductible
B. The provider is paid a capitation fee rather than billing for each visit
C. The member's premium is reduced each time an in-network provider is used
D. The provider has agreed to network terms or negotiated rates

**481. What is a point-of-service plan designed to combine?**

A. Managed-care features with some choice to use out-of-network providers
B. A high-deductible health plan with a tax-advantaged health savings account
C. Basic hospital coverage with a separate supplemental major medical policy
D. Group medical coverage with a disability income rider for the employee

**482. What does a health plan's provider network usually refer to?**

A. Doctors and hospitals the member has used in the past plan year
B. Doctors, hospitals, and providers that contract with the plan
C. Employers and associations that sponsor the plan's group contracts
D. Licensed producers and agencies appointed to sell the plan's policies

**483. What is a common result of using an out-of-network provider under many managed-care plans?**

A. The member's coverage is canceled for violating the plan's network rules
B. The provider must accept the plan's in-network rate as payment in full
C. The member may pay higher out-of-pocket costs or receive reduced benefits
D. The member's out-of-pocket maximum is waived for the rest of the year

**484. What is utilization review mainly used for in health insurance?**

A. To determine whether an applicant is insurable before a policy is issued
B. To decide which of two plans pays first when a member has duplicate coverage
C. To calculate the premium rate an employer group will pay at its next annual renewal
D. To review whether services are medically necessary or appropriate under the plan

**485. A plan requires approval before a nonemergency hospital admission. What is this requirement usually called?**

A. Preauthorization
B. Dividend option
C. Subrogation
D. Reinstatement

**486. Under federal law, how must a health plan handle emergency services received from an out-of-network provider?**

A. Emergency care must be covered without prior authorization, but the plan may apply its higher out-of-network deductible and coinsurance
B. Emergency care must be covered without prior authorization, applying the prudent layperson standard and no greater cost sharing than in-network
C. Emergency care must be covered at in-network cost sharing, but the plan may deny the claim if the final diagnosis was not an emergency
D. Emergency care must be covered at in-network cost sharing, but the out-of-network provider may balance bill the insured for remaining charges

**487. What is a deductible in a medical expense policy?**

A. The fixed amount the insured pays at each office visit or prescription fill
B. The percentage of covered expenses the insured shares with the plan after the deductible
C. The amount the insured pays before the plan begins paying covered expenses
D. The most the insured will pay for covered expenses during the plan year

**488. What does coinsurance usually mean in health insurance?**

A. The insured pays a fixed dollar amount for each covered service at the time of care
B. Two insurers covering the same person coordinate so that benefits are not duplicated
C. The insured pays the full cost of covered services until the deductible is satisfied
D. The insured and insurer share covered costs by percentage after the deductible

**489. A family health plan has a $1,000 individual deductible and a $2,000 family deductible. What does the family deductible do?**

A. It requires each family member to pay $2,000 before benefits begin
B. It doubles every deductible when a new dependent is added

C. It applies only to hospital stays

D. Once covered expenses from family members reach $2,000 combined, the deductible is satisfied for the whole family

**490. What is the purpose of an out-of-pocket maximum?**

A. To cap the total benefits the plan will pay over the insured's lifetime

B. To limit the insured's covered cost sharing during a plan period

C. To limit the premium the insurer may charge the insured in a plan year

D. To set the amount the insured pays before the plan's coinsurance begins

**491. What is a major medical policy generally designed to cover?**

A. A fixed daily cash benefit paid to the insured for each day of hospital confinement

B. Routine doctor visits and preventive care paid in full with no deductible or coinsurance

C. Large or broad medical expenses subject to deductibles, coinsurance, limits, and exclusions

D. Lost income when sickness or injury keeps the insured from working for an extended period

**492. A hospital expense benefit is most directly related to which type of cost?**

A. Surgeon's fees paid according to a schedule of covered procedures

B. Physician office visits and outpatient diagnostic tests covered by the policy

C. Income lost while the insured is confined to a hospital and unable to work

D. Room, board, and hospital-related charges covered by the policy

**493. What does a surgical expense benefit usually help pay for?**

A. Covered surgical procedures and related charges

B. Physician office visits and routine preventive care

C. Hospital room and board during a covered stay

D. Diagnostic lab work and X-rays ordered before admission

**494. Why must limited-benefit health policies be explained carefully to applicants?**

A. They are required by law to be sold only alongside a major medical policy

B. They may pay only specified amounts or cover only specified conditions or services

C. They are issued on a guaranteed renewable basis and cannot exclude any preexisting condition

D. They count as minimum essential coverage that satisfies major medical requirements

**495. What does the term 'usual, customary, and reasonable' (UCR) commonly relate to?**

A. How a plan calculates the coinsurance percentage the insured must pay

B. How a network provider agrees to discount fees under a PPO contract

C. How a plan determines an allowable charge for a covered medical service

D. How an insurer sets the annual deductible per covered family member

**496. Why are exclusions important in a medical expense policy?**

A. They replace the need for a deductible

B. They guarantee every claim is paid

C. They automatically expand coverage for every condition

D. They identify services or situations the policy does not cover

**497. Why is the definition of disability important in a disability income policy?**

A. It determines when the insured may qualify for disability benefits

B. It sets the length of the elimination period before benefits begin

C. It fixes the monthly benefit amount as a percentage of prior earnings

D. It establishes how long benefits continue once a claim has been approved

**498. What is the elimination period in a disability income policy?**

A. The deadline to file a property claim

B. The waiting period before disability benefits begin

C. The time before a life policy can name a beneficiary

D. The period when the insurer cannot collect premiums

**499. What does the benefit period in disability income insurance describe?**

A. How long the insured must wait after a disability begins before benefits start
B. How long the policy stays in force before the insurer may raise the premium
C. How long benefits may be payable after a covered disability begins
D. How long the insured must have been employed before coverage becomes effective

**500. What does a residual disability benefit generally address?**

A. Total loss of income when the insured cannot perform any occupation
B. A lump sum paid when the insured suffers the loss of a limb or eyesight
C. Recurring benefits when a past disability returns after a short recovery
D. Partial loss of income when the insured can work but not at full capacity

**501. Under an 'own-occupation' definition of total disability, the insured is considered totally disabled when unable to do what?**

A. Perform the substantial duties of the specific occupation the insured was working in at the time of disability
B. Perform the duties of any occupation for which the insured is reasonably suited by education, training, or experience
C. Perform any gainful work at all, regardless of the insured's prior training, income level, or experience
D. Earn at least the same income as before the disability, whether in the same occupation or a different one

**502. Compared with own-occupation wording, an any-occupation disability definition is generally more restrictive because it considers whether the insured can do what?**

A. Perform the main duties of the insured's own regular occupation
B. Work in another suitable occupation based on policy terms
C. Pay premiums during the elimination period without hardship
D. Qualify for Social Security disability benefits at the same time

**503. What is a key feature of a noncancelable disability income policy?**

A. The insurer cannot cancel coverage but may raise premiums for an entire class of insureds when renewing
B. The insurer may refuse renewal at any anniversary but must keep the premium rate level for the policy term
C. The insurer cannot cancel or raise premiums if the insured pays required premiums, subject to policy terms
D. The insured is guaranteed a benefit period that lasts until the insured's normal retirement age

**504. How does guaranteed renewable disability coverage generally differ from noncancelable coverage?**

A. The insurer may raise rates for an individual insured but cannot cancel coverage for any reason
B. The insurer may decline to renew at each anniversary but cannot change the premium during the year
C. The insured is guaranteed level premiums for life but the insurer may cancel coverage for poor claims
D. The insurer usually cannot cancel coverage but may raise rates by class, subject to policy terms

**505. What does the entire contract provision generally say?**

A. The policy, application, and attached papers make up the full contract
B. The policy and the producer's oral statements together make up the full contract
C. The producer may change the contract by endorsing the application with the insured
D. The application alone is the full contract once the first premium has been paid

**506. What is the purpose of a time limit on certain defenses provision?**

A. To limit how long the insured may wait after a loss before giving notice of the claim
B. To limit how long the insurer can use certain misstatements to void coverage or deny claims
C. To limit how long the insurer has to pay a claim after receiving proof of loss
D. To limit how long the insured has to sue the insurer over a denied claim

**507. What does a grace period allow in a health insurance policy?**

A. Extra time to file a claim after the notice-of-claim deadline has already passed
B. Extra time to apply for reinstatement without paying the overdue premiums
C. Extra time to pay a premium after the due date while coverage may remain in force
D. Extra time to review a new policy and return it for a full premium refund

**508. What does reinstatement usually involve?**

A. Renewing a policy at its anniversary at the same premium
B. Returning a new policy during the free-look period
C. Converting group coverage to an individual policy
D. Restoring a lapsed policy after requirements are met

**509. What is the purpose of the notice of claim provision?**

A. To require timely notice to the insurer after a covered loss begins or occurs
B. To require the insurer to supply claim forms within a set number of days
C. To require the insured to submit written proof of the loss within a set time
D. To require the insurer to pay benefits promptly after receiving proof of loss

**510. What is proof of loss?**

A. A policy advertisement
B. Documentation submitted to support a claim
C. A license renewal notice
D. A property inspection certificate

**511. A legal actions provision usually limits what?**

A. How long the insurer may take to investigate a claim before paying
B. When the insurer may contest statements made in the application
C. When a lawsuit may be brought against the insurer over a claim
D. When the insured must give written notice of a loss to the insurer

**512. In health insurance, a change of beneficiary provision is most relevant when the policy includes what kind of benefit?**

A. A disability income benefit paid to the insured
B. A medical expense benefit paid directly to a provider
C. A waiver of premium benefit during total disability
D. A death or survivor benefit payable to another person

**513. In group health insurance, who is usually the policyholder?**

A. The employer or sponsoring organization
B. The hospital that treats the employee
C. Every individual employee separately
D. The state insurance exam vendor

**514. What does a certificate of coverage usually provide to a group member?**

A. An individually owned contract the member keeps on leaving the group
B. A summary of the member's benefits and coverage under the group policy
C. A copy of the master policy with the member named as the policyholder
D. A guarantee of conversion to a group plan at a different employer

**515. Why does a group health plan use a probationary (waiting) period?**

A. To limit the window in which an eligible employee may enroll without underwriting
B. To delay coverage for preexisting conditions during the first policy year
C. To define when a new employee or member may become eligible for coverage
D. To allow the insurer to underwrite each employee before the group is issued

**516. In a contributory group health plan, what does contributory mean?**

A. The provider network pays claims directly without an insurer
B. No one pays any premium
C. Only the insurer pays the premium
D. Covered employees pay part of the premium

**517. At a general exam level, what is COBRA continuation coverage designed to do?**

A. Allow certain qualified beneficiaries to continue group health coverage for a limited time after qualifying events

B. Require employers to keep paying the full premium for former employees who lost coverage due to a qualifying event

C. Convert group coverage into a permanent individual policy that the former employee keeps for life at group rates

D. Provide free state-funded health coverage to any worker who is laid off until new employment is found

**518. What is the purpose of coordination of benefits in group health insurance?**

A. To combine the deductibles of two plans into a single higher family deductible

B. To determine payment order when a person is covered by more than one plan

C. To require a spouse's plan to pay first whenever both spouses are employed

D. To allow the insured to collect full benefits from each plan for the same expense

**519. What is a group health conversion privilege generally intended to allow?**

A. A covered person may keep the same group rates after leaving by paying the employer's share of premium

B. A covered person must pass new medical underwriting to obtain coverage after group coverage ends

C. A covered person may change to individual coverage when group coverage ends, if policy terms allow

D. A covered person may transfer group coverage to a new employer's plan without a waiting period

**520. At a general level, Medicare Part A is most commonly associated with which coverage?**

A. Prescription-only insurance

B. Dental-only insurance

C. Homeowners liability insurance

D. Hospital insurance

**521. At a general level, Medicare Part B is most commonly associated with what type of coverage?**

A. Medical insurance for services such as doctor visits and outpatient care

B. Hospital insurance for inpatient stays and skilled nursing facility care

C. Prescription drug coverage offered through private plans approved by Medicare

D. Private-plan coverage that bundles hospital, medical, and drug benefits together

**522. What is Medicare Advantage generally known as?**

A. A supplemental policy that pays Original Medicare's deductibles, also called Medigap

B. A private-plan alternative for receiving Medicare benefits, also called Part C

C. The prescription drug benefit offered through private plans, also called Part D

D. The hospital insurance portion funded by payroll taxes, also called Part A

**523. What is the basic purpose of a Medicare Supplement policy?**

A. To replace Original Medicare with a private managed care plan

B. To add prescription drug coverage to a Medicare Advantage plan

C. To help pay certain out-of-pocket costs under Original Medicare

D. To pay for long-term custodial care Medicare does not cover

**524. Long-term care insurance is mainly designed to help pay for what?**

A. Acute hospital care and rehabilitation after a sudden illness or injury that is expected to resolve completely

B. Lost wages when a chronic illness or disability prevents the insured from continuing to work at a regular job

C. Out-of-pocket costs such as deductibles and coinsurance that remain after Medicare pays for covered services

D. Care services needed because of chronic illness, disability, or inability to perform activities of daily living

**525. Which item is an example of an activity of daily living often used in long-term care insurance?**

A. Bathing

B. Filing a property claim

C. Driving a commercial truck

D. Choosing a life insurance beneficiary

**526. In long-term care insurance, what is an elimination period?**

A. A waiting period after policy issue before coverage for a preexisting condition begins
B. A waiting period before benefits become payable after the insured qualifies for benefits
C. A period during which the insurer may still contest statements made in the application
D. A maximum period during which benefits are payable once a covered claim is approved

**527. Which health policy renewability provision gives the insurer the least ability to cancel coverage during the policy term?**

A. Optionally renewable
B. Conditionally renewable
C. Noncancelable
D. Cancelable at will

**528. In a guaranteed renewable health policy, what right does the insurer usually keep?**

A. The right to refuse renewal at any anniversary if the insured's health has declined
B. The right to raise an individual insured's premium based on claims experience
C. The right to add exclusions for conditions that develop after the policy is issued
D. The right to change premiums by class, subject to policy terms and law

**529. What does an optionally renewable health policy allow the insurer to do?**

A. Choose not to renew on a policy anniversary or premium due date, subject to the contract
B. Renew only if the insured has no claims
C. Cancel during the grace period only
D. Never increase premiums

**530. What is the main purpose of a probationary period in a health insurance policy?**

A. To delay payment of benefits after a disability begins
B. To delay coverage for certain illnesses after the policy starts
C. To delay the insurer's right to contest the application
D. To delay coverage for accidental injury once the policy starts

**531. Which statement best describes the time limit on certain defenses provision?**

A. It limits the insured's ability to sue the insurer over a denied claim once a specified period has passed after proof of loss is filed
B. It limits the time the insured has to give notice and file proof of loss before the insurer may deny the claim for late filing
C. It limits the insurer's ability to deny claims based on misstatements after a specified period, except as allowed by the policy and law
D. It allows the insurer to rescind the policy for any misstatement at any time, provided the misstatement was material to the risk

**532. What does a reinstatement provision usually address?**

A. How a policy may be renewed at each anniversary
B. How a claim is paid after a policy has lapsed
C. How overdue premiums are waived during disability
D. How a lapsed policy may be put back in force

**533. Under many health policies, what is the purpose of a grace period?**

A. To let the insured pay a premium shortly after the due date while coverage may remain in force
B. To let the insured return the policy shortly after delivery and receive a full premium refund
C. To let the insurer delay paying a claim shortly after proof of loss while it investigates
D. To let the insured skip a premium without owing it later while the policy stays in force

**534. What does the physical examination and autopsy provision usually permit?**

A. The insurer may require a medical examination before renewing the policy at each anniversary
B. The insurer may require reasonable medical examinations related to a claim while it is pending
C. The insured may demand an independent examination at the insurer's expense before a claim is denied
D. The insurer may order an autopsy after a death claim even where state law prohibits it

**535. What is the legal actions provision in a health policy mainly designed to do?**

A. Set time limits for the insurer to pay a claim
B. Set time limits for giving the insurer notice of a claim
C. Set time limits for bringing a lawsuit over a claim
D. Set time limits for contesting the application

**536. What does a change of beneficiary provision usually allow in a health or accident policy with death benefits?**

A. The beneficiary may change the designation to another person with the insurer's consent
B. The policyowner must obtain the current beneficiary's written consent before making any change
C. The insurer may change the beneficiary if the named person cannot be located at the time of death
D. The policyowner may change the beneficiary unless the beneficiary designation is irrevocable

**537. Why does a health insurer use underwriting?**

A. To evaluate risk and decide whether to issue coverage and on what terms
B. To verify that a claim is medically necessary before benefits are paid
C. To determine how much of a covered charge the insured must pay out of pocket
D. To confirm that the producer disclosed all policy terms before the sale

**538. Which factor is commonly relevant in health insurance underwriting?**

A. Favorite color
B. Medical history
C. Property tax bill
D. Type of car owned

**539. What is an exclusion rider sometimes used for in individual health insurance?**

A. To add coverage for a specified condition in exchange for an extra premium
B. To charge a higher premium for a substandard risk instead of restricting any benefits
C. To exclude or limit coverage for a specified condition or hazard, where allowed
D. To waive the preexisting condition limitation for a specified health condition

**540. What is the purpose of a preexisting condition limitation?**

A. To exclude coverage for any illness or injury that first develops during the initial year the policy is in force
B. To reduce the benefit amount for conditions that were disclosed and accepted during underwriting
C. To require a higher premium for applicants who reported a chronic condition on the application
D. To limit coverage for a condition that existed before coverage began, subject to policy terms and law

**541. What does proof of loss usually mean in a health insurance claim?**

A. Documentation submitted to support that a covered loss occurred
B. A document proving the insurer is profitable
C. A replacement for the policy application
D. The producer's sales script

**542. If a health policy requires notice of claim, what is the insured generally expected to do?**

A. Submit complete written proof of the loss within the required time period
B. Tell the insurer about a covered loss within the required time period
C. File a lawsuit against the insurer if the claim is not paid within the period
D. Wait for the insurer to send claim forms before reporting the loss

**543. What is a common reason an insurer may deny a health claim?**

A. The insured submitted the claim on time
B. The deductible had already been met and all conditions were satisfied
C. The claimed expense is excluded or not covered by the policy
D. The policy was active and the service was covered

**544. What does coordination of benefits help prevent in group health coverage?**

A. Claims being denied under a preexisting condition limitation
B. The secondary plan from paying any portion of the claim
C. Dependents from being covered under more than one plan
D. Duplicate benefit payments that exceed covered expenses

**545. A health policy may be non-renewed only for reasons listed in the contract - such as the insured reaching a stated age or losing employment - but never because the insured's health worsens. Which renewability classification is this?**

A. Optionally renewable
B. Guaranteed renewable
C. Cancelable
D. Conditionally renewable

**546. What is utilization review designed to evaluate?**

A. Whether a provider's billed charges fall within usual, customary, and reasonable limits
B. Whether healthcare services are medically necessary and appropriate under plan rules
C. Whether an applicant's health history makes the risk acceptable for coverage
D. Whether a claimant has submitted timely notice and complete proof of loss

**547. What is a waiver of premium rider in a disability or health-related policy designed to do?**

A. Refund premiums already paid if the insured becomes totally disabled
B. Pay the insured a monthly benefit equal to the premium during a hospital stay
C. Waive future premiums if the insured meets the policy's disability requirements
D. Keep the policy in force without premiums once the insured reaches a stated age

**548. What is the main purpose of a guaranteed insurability rider?**

A. Allow the insured to reinstate a lapsed policy at any time without paying the overdue premiums or interest
B. Guarantee that the insurer will renew the policy each year at the original premium regardless of health changes
C. Allow the insured to increase the monthly benefit automatically each year to keep pace with inflation
D. Allow the insured to buy additional coverage later without new evidence of insurability, subject to rider terms

**549. Which policy is designed to pay a specified benefit when the insured is diagnosed with a covered serious illness?**

A. Critical illness policy
B. General liability policy
C. Workers compensation policy
D. Homeowners policy

**550. What does a hospital indemnity policy typically pay?**

A. The full billed hospital charges, reimbursed at 100 percent once the insured has satisfied a deductible
B. A stated benefit for covered hospitalization, regardless of the actual amount of the hospital bill
C. A percentage of the hospital's actual charges, after applying the major medical plan's deductible and coinsurance
D. Reimbursement of the physician's fees for outpatient office visits, with no benefit for inpatient stays

**551. What is accident-only health insurance designed to cover?**

A. Covered losses resulting from sicknesses, not accidents
B. Both accidents and sicknesses after a short waiting period
C. Covered losses resulting from accidents, not sicknesses
D. Accidents that occur at work, similar to workers compensation

**552. What is a dental insurance waiting period?**

A. A time when all cosmetic procedures are covered
B. A period when premiums are waived automatically
C. A waiting period for auto collision coverage
D. A period before certain dental benefits are available

**553. Which statement best describes vision insurance?**

A. It often helps pay for routine eye exams, lenses, frames, or contacts subject to plan limits
B. It pays the full cost of eye surgery and treatment of eye disease, with no plan limits
C. It is a required component of every adult major medical plan sold under the ACA
D. It reimburses eyewear and exams at 100 percent once the major medical deductible is met

**554. What does a specified disease policy cover?**

A. Any sickness diagnosed after the policy's effective date
B. A named disease or group of diseases listed in the policy
C. Preexisting conditions that a major medical plan has excluded
D. Accidental injuries, with sickness excluded from coverage

**555. What is a common purpose of a long-term care inflation protection feature?**

A. Keep premiums level regardless of the insured's age at issue
B. Extend the benefit period so benefits are paid for life
C. Help benefits keep pace with rising care costs over time
D. Shorten the elimination period as care costs rise over time

**556. Which feature is most directly related to how long long-term care benefits may be paid?**

A. Open enrollment poster
B. Producer appointment
C. Copayment
D. Benefit period

**557. In group health insurance, what is the master policy?**

A. The contract issued to the employer or group sponsor
B. The certificate issued to each employee covered under the plan
C. The enrollment application signed by each employee
D. The summary of benefits given to eligible group members

**558. What does a certificate of insurance provide to a group member?**

A. The full contract terms, which control over the master policy
B. Evidence and summary of the member's coverage under the group policy
C. Ownership rights in the master policy, with the right to amend it
D. A guarantee that the coverage will continue after employment ends

**559. What is contributory group health coverage?**

A. Only the employer may file claims
B. Coverage applies only after Medicare begins
C. Employees pay part of the premium cost
D. The insurer contributes to every employee's retirement account

**560. Why do group health plans often have eligibility requirements?**

A. To prevent all claims from being filed
B. To eliminate the need for a master policy
C. To convert health insurance into property insurance
D. To define who may enroll and when coverage begins

**561. What is the main purpose of COBRA continuation coverage?**

A. Allow certain individuals to continue group health coverage temporarily after qualifying events
B. Require employers to pay the premium for former employees for up to 18 months after termination
C. Convert group health coverage into an individual policy permanently with no premium increase
D. Allow individuals to keep group coverage indefinitely once they become eligible for Medicare

**562. What is an unfair claims practice?**

A. A claim payment made before the insurer completes a full investigation
B. Improper claim-handling conduct prohibited by insurance law or regulation
C. A claimant's failure to submit proof of loss within the required period

D. An insurer's decision to deny a claim falling under a policy exclusion

**563. Why must producers avoid misrepresentation when selling health insurance?**

A. Misrepresentation makes the producer, not the insurer, liable to pay the claim
B. Any misstatement by the producer automatically voids the policy at claim time
C. Consumers rely on accurate explanations of benefits, exclusions, and limitations
D. Misrepresentation is treated as fraud by the applicant rather than the producer

**564. What is twisting in insurance sales?**

A. Returning part of the commission to the applicant to induce a sale
B. Making false statements about an insurer's financial condition
C. Pressuring an applicant into buying coverage through threats, intimidation, or force
D. Inducing a policy replacement through misleading or incomplete comparisons

**565. What should a producer do when a health policy has important limitations?**

A. Explain the limitations clearly and avoid suggesting the policy covers everything
B. Refer the applicant to the insurer's claims department for any questions about limits
C. Disclose the limitations after the policy is delivered, during the free look period
D. Rely on the outline of coverage alone, since it replaces any verbal explanation

**566. Why is suitability important when discussing health or supplemental coverage?**

A. The insurer must approve the application once suitability has been documented
B. The recommended product should reasonably fit the consumer's needs and circumstances
C. The producer is relieved of any liability once the consumer signs a suitability acknowledgment form
D. The product with the lowest premium must be recommended regardless of benefits

**567. A policy has a $1,000 deductible and 80/20 coinsurance after the deductible. If a covered bill is $6,000, how much is subject to coinsurance after the deductible?**

A. $1,000
B. $5,000
C. $6,000
D. $7,000

**568. In the same scenario, with a $1,000 deductible and 80/20 coinsurance on a $6,000 covered bill, what is the insured's coinsurance amount after the deductible?**

A. $500
B. $1,000
C. $1,200
D. $5,000

**569. What is an out-of-pocket maximum designed to do?**

A. Cap the total benefits the insurer will pay over the insured's lifetime
B. Set the amount the insured must pay before the plan begins to pay
C. Limit the insured's covered cost-sharing for a policy period
D. Limit the premium increases an insurer may impose at each renewal

**570. What does prior authorization usually require?**

A. A written referral from the insured's producer before a specialist visit
B. Review of a claim after the service is rendered to confirm medical necessity
C. Payment of the full charge up front, with reimbursement after plan review
D. Plan approval before certain services are provided or paid as covered

**571. A PPO member uses an out-of-network provider. What is a common result?**

A. The member may pay more out of pocket than with an in-network provider
B. The plan pays nothing, because PPOs cover in-network providers exclusively
C. The member must first obtain a referral from a primary care gatekeeper
D. The out-of-network provider is bound to accept the plan's negotiated rate

**572. A plan places a high-cost biologic injection on its specialty tier. What does that typically mean for the member?**

A. The drug is free after one retail fill
B. The highest cost-sharing level, and the drug often must come from a designated specialty pharmacy
C. The drug is not FDA approved
D. The drug can be prescribed only by a hospital

**573. What does a drug tier usually affect?**

A. The producer's license type
B. The length of a life insurance contestability period
C. The deductible for homeowners insurance
D. The insured's cost-sharing for that medication

**574. A member insists on the brand-name drug even though the plan's formulary designates an equivalent generic. How do many plans handle the claim?**

A. The brand is covered at the generic copay automatically
B. The member pays the generic copay plus the cost difference between the brand and the generic, unless the prescriber shows the brand is medically necessary
C. The claim is always denied entirely
D. The pharmacy is required to dispense the generic anyway

**575. Why are exclusions important in a health insurance policy?**

A. They list the services the policy covers in full without any cost-sharing
B. They set the maximum benefit the insurer will pay for each covered service
C. They identify services, conditions, or circumstances the policy does not cover
D. They describe the conditions the insured must meet before the insurer is obligated to pay a claim

**576. What is the best first step when a health claim is denied?**

A. File a lawsuit against the insurer immediately, since the legal actions provision starts running at denial
B. File a complaint with the state insurance department before contacting the insurer about the denial
C. Resubmit the same claim unchanged, since a second submission is reviewed by a different claims examiner
D. Review the explanation of benefits and policy provisions to understand the reason for denial

**577. Under the entire contract provision of an individual accident and sickness policy, which documents together make up the whole agreement between the parties?**

A. The policy, the application, and any statements the producer made verbally at the point of sale
B. The policy alone, since the application is only a marketing record
C. The policy plus any application attached to it when issued
D. The policy and the insurer's published underwriting manual

**578. An insured's individual health policy has been in force for four years when the insurer discovers a non-fraudulent misstatement on the application. Under the time limit on certain defenses provision, what may the insurer generally do?**

A. Rescind the policy back to its original issue date, since misstatements remain contestable
B. Reduce all future benefits proportionally, as it may for a misstatement of age
C. Void the policy but refund all premiums paid, since the error was not fraudulent
D. Nothing based on that misstatement, because the contestable window has closed

**579. Under the uniform grace period provision, which premium mode is matched with the correct minimum grace period?**

A. Quarterly premiums, 31 days
B. Annual premiums, 10 days
C. Monthly premiums, 31 days
D. Weekly premiums, 15 days

**580. A lapsed individual health policy is reinstated on June 1. The insured is hospitalized on June 5 for an illness that began June 4. How is the claim generally treated under the reinstatement provision?**

A. Paid in full, because reinstatement restores coverage retroactively to the lapse date

B. Denied, because sickness is covered only if it begins more than 10 days after the reinstatement date

C. Paid at 50 percent, because benefits under a reinstated policy phase in gradually over the first 30 days

D. Denied, because a reinstated policy excludes sickness for one year after the reinstatement date

**581. Under the NAIC Uniform Individual Accident and Sickness Policy Provisions, the notice of claim provision requires the claimant to notify the insurer within what time frame?**

A. Within 60 days after the insurer furnishes claim forms, and not before

B. Within 3 years after the loss, the same outer limit for legal actions

C. Within 20 days after the loss begins, or as soon as reasonably possible

D. Within 90 days after the loss, with no allowance for late notice

**582. An insurer receives notice of claim but fails to send the claimant the required claim forms within the time allowed. What is the usual consequence under the claim forms provision?**

A. The insurer must pay a statutory penalty directly to the claimant in addition to the claim benefit

B. The claim is deemed approved and must be paid in full without any further proof from the claimant

C. The claimant must wait until the forms actually arrive, and the proof of loss deadline is extended accordingly

D. The claimant may submit written proof of the nature and extent of the loss in any reasonable form

**583. Under the NAIC Uniform Individual Accident and Sickness Policy Provisions, written proof of loss is generally due within how long after the date of loss, or after the end of each period for which the insurer is liable for periodic payments?**

A. 20 days

B. 45 days

C. 90 days

D. 180 days

**584. Under the NAIC Uniform Individual Accident and Sickness Policy Provisions, the legal actions provision imposes which pair of limits on an insured who wants to sue the insurer over a claim?**

A. Suit may not be filed until 60 days after proof of loss is furnished, and not more than 3 years after proof of loss was required

B. Suit may be filed as soon as proof of loss is furnished, but must be filed within 1 year after the date of the loss

C. Suit may be filed only after the insurer issues a written denial of the claim, and must be filed within 90 days after the date of that denial

D. Suit may not be filed until the policy is surrendered to the insurer, and not more than 5 years after the date of loss

**585. The physical examination and autopsy provision permits an insurer to do which of the following?**

A. Require the insured to undergo an annual wellness screening at the insured's expense as a condition of keeping the policy in force, and deny claims if it is skipped

B. Examine the insured at the insurer's own expense as often as reasonably necessary while a claim is pending, and order an autopsy where not forbidden by law

C. Examine the insured no more than once per policy year during a pending claim, with the insured paying the examiner's fee and any travel costs

D. Order an autopsy in any death claim regardless of state law, and examine the insured at the insured's expense as often as the insurer chooses

**586. A health policy's payment of claims provision includes a facility of payment clause. What does that clause allow the insurer to do?**

A. Delay payment of the entire benefit until an executor or administrator of the insured's estate has been formally appointed by the probate court

B. Pay the entire benefit directly to the producer who wrote the policy, who then distributes it to the insured's heirs

C. Substitute a lifetime annuity for any lump-sum benefit whenever the payee is a minor or the insured's estate

D. Pay a limited amount to a relative by blood or marriage who appears equitably entitled, when no valid beneficiary exists

**587. An insured with a disability income policy containing the optional change of occupation provision moves from an office job to roofing work without telling the insurer, then is injured. How are benefits typically handled?**

A. Benefits are reduced to the amount the premium paid would have purchased at the more hazardous occupation's rate

B. The claim is denied outright, because failing to report the occupation change is treated as a material misrepresentation

C. Benefits are paid in full at the policy's stated amount, because the occupation classification is fixed at the time of issue

D. Benefits are paid in full, but the insurer may bill the insured for the back premium owed at the more hazardous rate

**588. A claim reveals that an insured understated her age on the health insurance application. Under the optional misstatement of age provision, the insurer will most likely:**

A. Refer the matter to the state insurance fraud bureau and withhold all benefits until the investigation is complete

B. Adjust the benefit to what the premium actually paid would have purchased at the insured's correct age

C. Rescind the contract and refund the premiums paid, regardless of how long the policy has been in force

D. Pay the full stated benefit and bill the insured for the back premium owed at the correct age, plus interest

**589. Which pair of optional uniform provisions allows an insurer to exclude liability for losses arising from the insured's own unlawful or impaired conduct?**

A. Unpaid premium, and conformity with state statutes

B. Other insurance in this insurer, and cancellation

C. Illegal occupation, and intoxicants and narcotics

D. Relation of earnings to insurance, and change of beneficiary

**590. What is the purpose of the optional relation of earnings to insurance provision in a disability income policy?**

A. To require the insured to submit tax returns and proof of earnings before the policy will be issued, so the benefit can be set at the correct level

B. To index the monthly benefit upward each year in step with the insured's rising earnings, so the benefit keeps pace with inflation

C. To make the policy pay first, before any group disability coverage the insured owns, whenever total coverage exceeds earnings

D. To reduce disability benefits when total coverage exceeds the insured's earnings, so the insured is not better off disabled than working

**591. A producer's business cards, appointment, and company signage lead a consumer to reasonably believe the producer can bind the insurer, even though the producer's contract says otherwise. Which type of authority is the consumer relying on?**

A. Apparent authority

B. Fiduciary authority

C. Express authority

D. Implied authority

**592. An insurance contract is described as aleatory. What does that mean?**

A. Only one of the two parties makes a legally enforceable promise under the contract

B. The dollar amounts exchanged by the two parties are likely to be unequal, depending on chance

C. Certain duties of the parties arise only if specified events, such as a covered loss, actually occur

D. The terms are drafted by one party and offered on a take-it-or-leave-it basis

**593. Because a health insurance policy is a contract of adhesion, how are genuinely ambiguous policy words usually construed by courts?**

A. By averaging the two competing interpretations

B. In favor of the insurer, since it accepted the risk

C. In favor of the insured, since the insurer drafted the language

D. Strictly according to the producer's sales illustration

**594. Which fact best demonstrates that a health insurance policy is a unilateral contract?**

A. The policy cannot take effect until the applicant's insurable interest in the insured has been proven in a court proceeding

B. The insured must keep paying premiums for the full policy term, or the insurer may sue for breach of contract to collect

C. Both parties exchange promises of equal value at the moment of issue, so each is bound to perform in return for the other

D. Only the insurer makes a legally enforceable promise, while the insured may stop paying premiums and simply let coverage end

**595. On a health insurance application, an applicant's statements about her health history are generally treated as which of the following?**

A. Representations, which must be substantially true to the best of the applicant's knowledge and belief

B. Warranties, which must be literally and exactly true, or the policy is void from the date of issue

C. Nonbinding statements of opinion that carry no underwriting consequence and cannot support rescission

D. Conditions precedent that suspend all coverage until each statement has been independently verified by the insurer

**596. An applicant is asked no direct question about a recent abnormal biopsy and says nothing about it. If the insurer later contests the policy on this basis, what is it alleging?**

A. Rebating of a premium inducement

B. Concealment of a material fact

C. Twisting to induce a replacement

D. Estoppel based on prior conduct

**597. An insurer knowingly accepts late premiums for two years, then tries to deny a claim on the ground that a premium was late. Which doctrine most likely prevents that denial?**

A. Indemnity, which limits the insured's recovery to actual loss and so prevents the insurer from profiting from a technical lapse

B. Subrogation, which transfers the insured's rights against a responsible third party to the insurer after a claim is paid

C. Estoppel, which bars the insurer from asserting a right its own conduct led the insured to believe was waived

D. Coinsurance, which splits covered costs between the insurer and the insured according to a fixed percentage formula

**598. When must insurable interest exist for an individual health insurance policy?**

A. Only at the time a claim is filed, when the insurer verifies that the claimant would actually suffer a loss

B. At no point, because insurable interest is a requirement of property and casualty insurance rather than health insurance

C. Continuously from application through claim, so the policy automatically terminates the moment the relationship ends

D. At the time of application, when the applicant must have a legitimate interest in the insured's continued well-being

**599. For health products that are still medically underwritten, such as disability income and long-term care, which practice most directly counteracts adverse selection?**

A. Requiring evidence of insurability and applying preexisting condition limits or waiting periods

B. Charging a single community-rated premium regardless of health, so applicants have no reason to conceal conditions

C. Paying producers a higher first-year commission on larger cases, so they bring in healthier applicants

D. Extending the free look period from 10 days to 30 days, giving the insurer more time to review the risk

**600. Reimbursement-type medical expense insurance reflects the principle of indemnity because it is designed to:**

A. Pay a fixed, predetermined amount for each day of treatment, regardless of what the care actually cost the insured

B. Restore the insured to the financial position held before the loss, without allowing a profit from the loss

C. Pay the full benefit to whichever party files a claim first, whether the insured, the provider, or another insurer

D. Pay the full benefit under each policy when two policies cover the same expense, so the insured collects twice

**601. An underwriter finds a coded entry in an applicant's Medical Information Bureau record suggesting a past cardiac condition. What is the correct use of that information?**

A. It may be used as the sole and sufficient basis for declining the application, since MIB codes are verified diagnoses

B. It must be ignored entirely, because MIB data is confidential and may be released only to the applicant's own physician

C. It may be used only as an alert to investigate further; the insurer may not decline or rate the applicant solely on the MIB record

D. It must be forwarded to the applicant's employer for verification before the underwriter may act on it, since employers hold the medical file

**602. Which statement accurately describes the Medical Information Bureau?**

A. A claims clearinghouse that reviews medical bills and pays providers directly on behalf of its member health insurers

B. A consumer credit bureau that assigns numeric scores insurers use to set health insurance premiums and classify risk

C. A federal agency that licenses health insurance producers and maintains a national database of their examination and disciplinary records

D. A member-supported information exchange whose coded records help member insurers detect omissions and fraud on applications

**603. An insurer declines an applicant based in part on information contained in a consumer report. Under the Fair Credit Reporting Act, what must the insurer do?**

A. Notify the applicant of the adverse action and identify the consumer reporting agency that furnished the report

B. Provide the applicant with a complete copy of the consumer report within 24 hours, along with the underwriter's notes

C. Pay the applicant a statutory penalty for the inconvenience and destroy the report so it cannot be used again

D. Nothing further, since the applicant consented to the report by signing the application's authorization

**604. How does an investigative consumer report differ from an ordinary consumer report?**

A. It is limited strictly to payment history, public records, and other documented data, with no personal contact permitted

B. It gathers information about character, reputation, and lifestyle through personal interviews with the applicant's associates

C. It is prepared by the insurer's own underwriting or claims staff rather than by an outside consumer reporting agency

D. It may be obtained without the applicant ever being told, because the interviews are conducted with third parties rather than the applicant

**605. During a health insurance application, the applicant mentions a hospitalization but asks the producer to leave it off the form to speed up approval. What must the producer do?**

A. Leave the question blank and submit the application, so the underwriter can request the details directly from the applicant

B. Record it in a private note kept in the producer's own office file, in case the insurer asks about it later

C. Record the information accurately and completely, and explain that omitting it could void coverage at claim time

D. Leave it off as requested, since the applicant who signs the form bears sole responsibility for its accuracy

**606. An applicant pays the initial premium with the application and receives a conditional receipt. What coverage does this create?**

A. Immediate coverage for a fixed number of days regardless of insurability, with the insurer bearing the full risk of loss until it formally decides on the application

B. No coverage of any kind until the policy is physically delivered to the applicant and the first premium is formally accepted by the home office

C. Permanent coverage on the terms applied for, which the insurer may not later rescind even if the application contained a material misrepresentation

D. Coverage effective as of the receipt's stated date only if the applicant proves to be insurable under the insurer's rules for the policy applied for

**607. A producer delivers a health policy that was applied for without any premium payment. What document does the producer normally need to collect along with the premium at delivery?**

A. A statement of continued good health confirming no change in the applicant's health since the application date

B. A signed conditional receipt so that coverage is backdated to the date the application was originally completed

C. A new attending physician statement because the original medical underwriting expires once the policy is issued

D. A signed delivery receipt in which the applicant waives the right to return the policy during the free look period

**608. No premium was submitted with a health insurance application and no receipt was issued. When does coverage generally become effective?**

A. On the date the application was signed, because the signed application itself serves as the applicant's consideration

B. On the date the policy is delivered and the initial premium is collected, provided the applicant is still in good health

C. On the date the underwriter approved the application, with coverage backdated to that date once the premium is received

D. On the date of the applicant's medical exam, since that is when the insurer first accepted the risk for underwriting

**609. A producer is replacing a client's existing individual health policy with a new one. Which practice is required?**

A. Cancel the existing policy as soon as the new application is signed so that the client does not pay two premiums while the new insurer's underwriting is still pending

B. Provide the required replacement notice and then cancel the existing policy once the new insurer's conditional receipt has been issued

C. Provide the required replacement notice and make sure the existing coverage stays in force until the new policy is actually issued and effective

D. Obtain the existing insurer's written consent to the replacement before the new application may be submitted for underwriting

**610. At the point of sale, why does a health insurance applicant sign a HIPAA-compliant authorization?**

A. It transfers ownership of the applicant's medical records to the insurer, which may then share them with any other insurer without further consent from the applicant

B. It authorizes the insurer to obtain protected health information from providers for underwriting purposes, and once signed it cannot be revoked until the policy is issued

C. It waives the applicant's right under the Fair Credit Reporting Act to be told when an adverse underwriting decision is based on information from a consumer report

D. It gives the insurer permission to obtain protected health information from providers for underwriting and claims purposes, and it may be revoked by the applicant

**611. Why are Medicare Supplement policies sold under standardized plan letters?**

A. So that a given plan letter provides the same core set of benefits from any insurer, letting consumers compare on price and service

B. So that every insurer offering a given plan letter must charge the same premium, leaving consumers to compare only on service quality

C. So that Medicare itself pays the standardized benefits directly, with the private insurer serving only as the administrator of the plan letter

D. So that each plan letter is assigned to a single insurer in each state, preventing duplicate offerings of the same benefits

**612. Which benefit is part of the core package that every standardized Medicare Supplement plan must include?**

A. The Medicare Part A hospital deductible for each benefit period, which every standardized plan letter must pay in full

B. Hospitalization coinsurance for Part A plus coverage of an additional 365 lifetime hospital days after Medicare benefits end

C. Skilled nursing facility coinsurance for days 21 through 100, paid in full by every standardized plan letter

D. Coverage of the Medicare Part B annual deductible, which every standardized plan sold since Part D began must include

**613. When does the Medicare Supplement open enrollment period begin, and how long does it last?**

A. It is a six-month period beginning with the first month the individual is entitled to Medicare Part A, whether or not enrolled in Part B

B. It is a seven-month period that begins three months before the month the individual turns 65 and ends three months after

C. It is a six-month period beginning with the first month the individual is both age 65 or older and enrolled in Medicare Part B

D. It is a three-month period beginning the month the individual first enrolls in Medicare Part B, whether before or after age 65

**614. A Medigap insurer wants to apply a preexisting condition waiting period to a new policyholder. Which statement is correct?**

A. The waiting period is capped at twelve months and may not be reduced by any prior coverage the applicant held

B. The waiting period may not exceed six months, but it applies in full regardless of the applicant's prior coverage

C. The waiting period may be applied only to applicants who enroll outside the six-month open enrollment period

D. The waiting period is capped at six months and must be reduced by the applicant's prior creditable coverage

**615. Which statement best describes a Medicare Advantage plan?**

A. A private plan under contract with Medicare that delivers the beneficiary's Part A and Part B benefits, often through a managed care network and frequently with extra benefits

B. A private supplemental policy sold alongside Original Medicare by private insurers that pays the deductibles and coinsurance left behind by Part A and Part B, using a standardized plan letter

C. A federal program administered directly by CMS that pays the beneficiary's Part A and Part B cost sharing in exchange for using a managed care network of providers

D. A savings account the beneficiary funds with pretax contributions to pay Part A and Part B premiums, with the federal government matching each contribution

**616. A client enrolled in a Medicare Advantage plan asks a producer to sell her a Medicare Supplement policy to fill in her plan's copayments. What is the correct response?**

A. Sell it, because Medigap coordinates with any form of Medicare coverage and will pay the plan's copayments as secondary coverage

B. Explain that a Medigap policy cannot pay benefits alongside a Medicare Advantage plan, so selling one for that purpose is prohibited

C. Sell it, provided she signs a statement acknowledging that the Medigap policy will pay only after her Medicare Advantage plan pays

D. Sell it only if her Medicare Advantage plan does not include Part D drug coverage, since a Medigap policy may not duplicate outpatient drug benefits

**617. A producer learns that a prospect already owns a Medicare Supplement policy and intends to keep it. Selling a second Medigap policy in this situation is:**

A. Permitted, because Medicare Supplement policies coordinate benefits with each other like group health plans

B. Permitted if the prospect signs a written statement acknowledging that the coverage will be duplicated

C. Prohibited, because knowingly selling duplicate Medicare Supplement coverage is an unfair trade practice

D. Prohibited only if the second policy carries the same plan letter as the policy the prospect intends to keep

**618. Coverage of Medicare Part B excess charges is a feature found only in a limited number of Medigap plan letters. What is a Part B excess charge?**

A. The portion of the Medicare-approved amount that remains after Part B pays its 80 percent share

B. The amount a beneficiary pays above the standard Part B premium because of higher income

C. The surcharge added to the Part B premium for each year the beneficiary delayed enrollment

D. The amount a nonparticipating provider may bill above the Medicare-approved amount

**619. Medigap Plans K and L differ structurally from most other lettered plans in what way?**

A. They pay a stated percentage of certain cost-sharing items and include an annual out-of-pocket limit, after which they pay covered costs in full for the rest of the year

B. They pay all Medicare cost-sharing items in full but impose an annual benefit maximum, after which the beneficiary must pay all covered costs personally for the rest of the calendar year

C. They are high deductible versions of Plans F and G, paying nothing until the beneficiary has met a deductible

that is set each year by Medicare

D. They are Medicare SELECT plans that pay full benefits only when the beneficiary uses network hospitals and providers selected by the insurer

**620. Which statement about Medicare Part D is accurate?**

A. It is mandatory outpatient prescription drug coverage administered directly by Medicare, and a beneficiary is enrolled automatically upon becoming entitled to Part A

B. It is voluntary outpatient prescription drug coverage offered through private plans, and a beneficiary who delays enrollment without creditable drug coverage may owe a permanent late enrollment penalty

C. It is voluntary outpatient prescription drug coverage offered through private plans, and a beneficiary who delays enrollment without creditable drug coverage pays a temporary penalty that ends after twelve months

D. It is prescription drug coverage that is built into every standardized Medicare Supplement plan letter, with the premium deducted from the beneficiary's Social Security benefits

**621. A client expects his new Medicare Supplement policy to pay for an extended stay in an assisted living facility. How should the producer respond?**

A. Confirm that every Medigap plan letter pays custodial care in an assisted living facility once the beneficiary has satisfied a 100-day waiting period

B. Explain that Plan G covers assisted living in full, but only after Medicare's skilled nursing facility benefit has been exhausted for the benefit period

C. Explain that Medigap fills gaps in Original Medicare and therefore does not pay for custodial long-term care, which requires a separate long-term care policy

D. Recommend adding a second Medigap policy with a different plan letter so the two policies together will cover the assisted living costs

**622. Which practice reflects proper suitability and marketing conduct when selling Medicare Supplement insurance?**

A. Collecting a full year of premium in advance so the rate is locked in permanently, and explaining that the free look period is waived once the first premium payment has been accepted by the issuing insurer

B. Describing the policy as endorsed by Medicare to build confidence, and documenting that the applicant understands the policy will replace rather than duplicate Original Medicare benefits

C. Comparing plans only on premium, since standardized benefits make everything else irrelevant, and relying on the applicant's verbal assurance that no other Medigap coverage is in force

D. Determining and documenting whether the applicant already has coverage that would duplicate the policy, and honoring the required free look period during which the policy may be returned for a full premium refund

**623. How are premiums for an individually purchased medical expense policy generally treated for federal income tax purposes?**

A. Deductible only as part of itemized medical expenses, and only to the extent total qualifying medical costs exceed the applicable percentage of adjusted gross income

B. Fully deductible from gross income regardless of the taxpayer's other circumstances

C. Never deductible under any circumstances

D. Deductible only if the policy also includes disability income coverage

**624. An individual pays the premiums for her own disability income policy with after-tax dollars and later becomes disabled. How are the monthly benefits treated?**

A. Fully taxable as ordinary income

B. Received free of federal income tax

C. Taxable only to the extent they exceed her prior salary

D. Taxable at capital gains rates

**625. An employer pays the entire premium for a group disability income plan and deducts the cost as a business expense. How are benefits paid to a disabled employee treated?**

A. Tax free to the employee because group coverage is always exempt

B. Tax free up to the elimination period, then taxable

C. Taxable income to the employee

D. Tax free to the employee but taxable to the employer

**626. Which set of conditions must generally be satisfied for an individual to be eligible to contribute to a Health Savings Account?**

A. Coverage under a qualified high deductible health plan, enrollment in Medicare Part A, and no participation in a general purpose flexible spending account

B. Coverage under any employer group health plan with an annual deductible, being under age 65, and having earned income at least equal to the contribution

C. Coverage under a qualified high deductible health plan, no other disqualifying coverage, and being claimed as a dependent on a parent's return if the parent is HSA-eligible

D. Coverage under a qualified high deductible health plan, no other disqualifying health coverage, not enrolled in Medicare, and not claimed as a dependent on another person's return

**627. A 45-year-old HSA owner withdraws funds to pay for a family vacation. What is the federal tax result?**

A. The distribution is included in gross income and is also subject to an additional penalty tax

B. Only the earnings portion is taxed, and no penalty applies

C. No tax, because HSA funds belong to the accountholder

D. Tax free, but the account must be closed

**628. A self-employed sole proprietor with net earnings from her business buys her own health insurance. Which statement describes the self-employed health insurance deduction?**

A. She may deduct premiums for herself, her spouse, and dependents only as an itemized medical expense, and only to the extent they exceed the applicable percentage of adjusted gross income

B. She may generally deduct premiums for herself, her spouse, and dependents in arriving at adjusted gross income, without itemizing, limited by her net earnings from self-employment

C. She may deduct premiums for herself only, because the deduction does not extend to a spouse or dependents unless they are also employed by the business

D. She may deduct premiums for herself, her spouse, and dependents in arriving at adjusted gross income, with no limit tied to the business's net earnings for the year

**629. How is a business overhead expense disability policy generally treated for federal tax purposes?**

A. Premiums are deductible as an ordinary business expense, and benefits are received tax free because they replace revenue the business has already lost

B. Premiums are not deductible, and benefits are received tax free by the business in the same manner as individual disability income benefits

C. Premiums are deductible as a business expense, and benefits are taxable to the business but are largely offset by the deductible expenses they reimburse

D. Premiums are deductible only by the disabled owner personally, and benefits are taxable to the owner as a substitute for lost salary

**630. A corporation buys and pays for a key person disability income policy on a vital executive, with benefits payable to the corporation. What is the tax treatment?**

A. Premiums are deductible as compensation, and benefits are taxable to the executive when paid

B. Premiums are deductible as an ordinary business expense, and benefits received are taxable income

C. Premiums are not deductible, and benefits received by the corporation are taxable as ordinary income

D. Premiums are not deductible, and benefits received by the corporation are not taxable income

**631. A child is covered as a dependent under both parents' group health plans and the parents are married and living together. Under the standard birthday rule, which plan is primary?**

A. The plan of the parent whose birthday falls earlier in the calendar year, regardless of birth year

B. The plan of the parent who is older, as measured by the full date of birth including the year of birth

C. The plan of the parent whose coverage has been in effect for the longer period of time

D. The plan of the parent who is the child's custodial parent under the most recent court order

**632. A disability income policy is written on a non-occupational basis. What does that mean for the insured?**

A. The policy covers disabilities arising on the job, supplementing the benefits workers compensation pays for work-related injuries

B. The policy covers disabilities arising off the job, because on-the-job injuries are expected to be handled by

workers compensation

C. The policy covers disabilities arising from any cause, but only while the insured is employed in the occupation shown on the application

D. The policy covers disabilities arising from sickness only, since occupational injuries are handled under workers compensation

**633. An insured's medical bills from a car accident are paid by her health plan, and she later wins a settlement from the driver who caused the crash. How does subrogation typically operate?**

A. The health plan must reimburse the at-fault driver's insurer for any settlement amounts that duplicate the medical benefits already paid

B. The at-fault driver's insurer must pay the health plan directly before the insured may file a claim under her own coverage

C. The health plan may recover from the settlement the amounts it already paid, so the insured is not paid twice for the same expenses

D. The insured keeps the entire settlement, because subrogation applies only to property insurance and not to health coverage

**634. Which statement best distinguishes a residual disability benefit from a straightforward partial disability benefit?**

A. Residual benefits pay a flat reduced percentage of the full benefit for a limited time, while a partial disability benefit is calculated from the percentage of income the insured has actually lost since returning to work

B. Residual benefits are payable only for disabilities caused by accidental injury, while a partial disability benefit is payable for disabilities caused by either sickness or injury

C. Residual benefits continue only while the insured remains totally disabled, while a partial disability benefit begins once the insured returns to work in a limited capacity

D. Residual benefits are calculated from the percentage of income the insured actually lost, while a partial disability benefit typically pays a flat reduced percentage of the full benefit for a limited time

**635. An employee is injured on the job and files a workers compensation claim. How does this typically interact with his employer's group health plan?**

A. Workers compensation pays for the work-related injury, and the group health plan generally excludes charges covered by workers compensation

B. The group health plan pays as primary for the work-related injury, and workers compensation reimburses the plan for any remaining balance

C. Workers compensation pays the medical expenses, while the group health plan pays the employee's lost wages for the duration of disability

D. The employee may submit the medical bills to either program, and whichever pays first becomes primary for that claim and all future claims

**636. A newborn is added to a parent's individual health policy. Which statement reflects the general standard for newborn coverage?**

A. Coverage generally begins at birth for injury and sickness, but congenital defects are excluded as preexisting conditions until the child has been enrolled for the policy's waiting period

B. Coverage generally begins at birth for injury, sickness, and medically diagnosed congenital defects, with the parent required to notify the insurer and pay any additional premium within the stated enrollment window

C. Coverage generally begins on the date the insurer receives the parent's written notice of birth, with the newborn treated as a late enrollee subject to underwriting if notice arrives over thirty days after birth

D. Coverage begins at birth without any premium or notice requirement, because the newborn is treated as an insured under the parent's policy until the next policy anniversary

**637. Under HIPAA's portability rules, which of the following counts as creditable coverage?**

A. Only coverage under an employer's group health plan

B. Any prior coverage, including plans consisting solely of excepted benefits such as stand-alone dental

C. Coverage under a group health plan, individual health insurance, Medicare, or Medicaid

D. Only coverage that was continuously in force for at least five years

**638. An employee declined her employer's group health plan because she was covered under her spouse's plan. Her spouse then loses his job, and with it her coverage. Under HIPAA's special enrollment rules, how long does she have to request enrollment in her own employer's plan?**

A. 30 days after the other coverage ends
B. 10 days after the other coverage ends
C. 90 days after the other coverage ends
D. She must wait for the plan's next annual open enrollment

**639. An employee's child loses Medicaid coverage, triggering a HIPAA special enrollment right in the parent's group health plan. How does the request deadline for this event differ from the deadline that applies to loss of other group coverage?**

A. There is no deadline for Medicaid-related events
B. It is longer: 60 days instead of 30 days
C. It is shorter: 15 days instead of 30 days
D. It is the same 30-day deadline that applies to all special enrollment events

**640. A group health plan wants to write eligibility rules that exclude certain individuals. Under HIPAA's nondiscrimination provisions, which basis for exclusion is prohibited?**

A. Whether the person works enough hours to be in an eligible employment class
B. Whether the person has satisfied the plan's waiting period
C. The person's status as a part-time versus full-time employee
D. The person's claims experience or genetic information

**641. Under HIPAA's breach notification requirements, after a covered entity discovers a breach of unsecured protected health information, affected individuals must be notified without unreasonable delay and no later than how long after discovery?**

A. 60 calendar days
B. 30 calendar days
C. 90 calendar days
D. 10 business days

**642. Which of the following is a covered entity directly subject to the HIPAA Privacy Rule?**

A. An employer acting purely in its role as an employer
B. A health plan, a health care clearinghouse, or a provider that transmits health information electronically for covered transactions
C. Any business that happens to store employee health records
D. Only federal government health programs

**643. Under the HIPAA Privacy Rule, what is protected health information (PHI)?**

A. Only health records stored in electronic databases
B. Only information about a patient's payment history
C. Individually identifiable health information transmitted or maintained in any form or medium
D. Any health statistic, even if it cannot be linked to a specific person

**644. A health insurer's claims department is fulfilling a records request. The HIPAA minimum necessary standard requires reasonable efforts to limit PHI to the minimum needed for the purpose, but that standard does NOT apply to which disclosure?**

A. A disclosure to a health care provider for treatment purposes
B. A routine internal report shared among the insurer's departments
C. A disclosure to a business associate performing claims analysis
D. A response to another insurer's request for underwriting records

**645. Under the HIPAA Privacy Rule, for which use of protected health information must a covered entity generally obtain the individual's written authorization?**

A. Disclosing records to another provider for the patient's treatment
B. Using records internally to process a claim for payment
C. Routine health care operations such as quality review
D. Using the individual's information for marketing communications

**646. The HIPAA Security Rule requires covered entities to protect which category of information?**

A. All business records of any kind
B. Electronic protected health information they create, receive, maintain, or transmit
C. Only paper medical charts kept on site
D. Only information posted on the entity's public website

**647. After a COBRA qualifying event, how long does a qualified beneficiary have to elect continuation coverage?**

A. 60 days, measured from the later of the date coverage ends or the date the election notice is provided
B. 31 days from the date of the qualifying event
C. 90 days from the date the plan administrator is notified
D. 45 days from the date coverage ends

**648. A COBRA qualified beneficiary is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage. What does the disability extension allow?**

A. Coverage may extend from 18 to a maximum of 29 months, and the plan may charge up to 150% of the premium during the 11-month extension
B. Coverage may extend to 36 months at the standard 102% premium
C. Coverage becomes free of charge for the duration of the disability
D. Coverage may extend indefinitely as long as the disability continues

**649. Which COBRA qualifying event entitles a covered spouse to up to 36 months of continuation coverage rather than 18?**

A. The employee's voluntary resignation
B. The employee's reduction in work hours
C. Divorce or legal separation from the covered employee
D. The employer switching insurance carriers

**650. An employee covered under a large employer's group health plan is fired for gross misconduct. What is the COBRA consequence?**

A. He may elect COBRA but only for 12 months
B. Termination for gross misconduct is not a qualifying event, so no COBRA continuation coverage is required
C. He may elect COBRA at 150% of the premium
D. He automatically receives 18 months of employer-paid coverage

**651. A worker will turn 65 in June. What is her Medicare Initial Enrollment Period?**

A. The 7-month window from March through September, spanning 3 months before, the month of, and 3 months after her 65th birthday month
B. The 3-month window of May, June, and July only
C. The calendar year in which she turns 65
D. The 30 days immediately following her birthday

**652. A man missed his Medicare Initial Enrollment Period and has no special enrollment right. When can he sign up, and when does coverage begin?**

A. Anytime during the year, with coverage starting immediately
B. October 15 through December 7, with coverage starting January 1
C. Only on his next birthday
D. During the General Enrollment Period, January 1 through March 31, with coverage starting the month after he signs up

**653. A 68-year-old delayed Medicare enrollment because she was covered by her employer's group health plan while still working. After she retires, how long does her Special Enrollment Period last?**

A. 3 months after employment ends
B. 8 months after the group coverage or the employment ends, whichever happens first
C. 12 months after the group coverage ends
D. 63 days after the group coverage ends

**654. Within a single Medicare Part A benefit period, how is cost sharing for an inpatient hospital stay structured?**

A. A flat daily copayment applies from the first day through the last

B. Medicare pays 80% of all charges and the patient pays 20% indefinitely

C. After the deductible, days 1-60 require no coinsurance; days 61-90 require a daily coinsurance; beyond day 90 the patient draws on 60 lifetime reserve days at a higher daily amount

D. The patient pays nothing for the first 150 days

**655. How is the Medicare Part B late enrollment penalty calculated for someone who delayed enrollment without qualifying coverage?**

A. A one-time fee equal to one month's premium

B. An extra 10% of the premium for each full 12-month period of delay, paid for as long as he has Part B

C. An extra 1% per month of delay, paid for 5 years

D. An extra 10% of the premium, paid for twice the number of years of delay

**656. A beneficiary went without Medicare drug coverage or other creditable prescription drug coverage for 20 months after becoming eligible. How is his Part D late enrollment penalty determined?**

A. 10% of his plan's premium for each year of delay, for as long as he keeps Part B

B. A flat annual surcharge set by his plan

C. There is no penalty as long as he eventually enrolls

D. 1% of the national base beneficiary premium for each month without coverage, added to his premium for as long as he has Medicare drug coverage

**657. A Medicare beneficiary's Medigap application falls under a guaranteed issue right. What does this require of the insurance company?**

A. It must sell her the policy and cannot use her answers to medical questions to deny coverage or change the price

B. It must sell her the policy but may triple the premium based on her health

C. It may decline her but must refund her application fee

D. It must give her a free policy for one year

**658. A 70-year-old whose Medigap open enrollment period ended years ago applies for a Medigap policy with no guaranteed issue right. What can the insurer do?**

A. Nothing; Medigap policies must always be issued on request

B. It may only adjust the deductible, not the premium

C. It may use medical underwriting to charge more or decline the application

D. It must issue the policy but may exclude all claims permanently

**659. How does the Medigap open enrollment period differ from Medicare's annual open enrollment?**

A. The Medigap open enrollment period repeats every fall

B. The Medigap open enrollment period is a one-time 6-month window that begins the first month the person has Part B and is 65 or older, and it does not repeat annually

C. The Medigap period lasts 7 months and recurs each birthday

D. There is no separate Medigap enrollment period

**660. How is the Medicaid program administered and funded?**

A. It is administered entirely by the federal government with no state role

B. It is a private insurance program subsidized through tax credits

C. Each state funds its program alone, with no federal money

D. States administer their own programs within federal requirements, with funding shared by the states and the federal government

**661. A retiree's income is too high for regular Medicaid eligibility, but she has very large ongoing medical bills. Under a state's medically needy option, how might she still qualify?**

A. By spending down: once her incurred medical expenses exceed the gap between her income and the state's medically needy income standard, she can become eligible

B. By transferring her income to a relative the month before applying

C. By paying a one-time enrollment fee to the state

D. She cannot qualify under any circumstances once income exceeds the limit

**662. A Medicaid enrollee is injured in an accident and also has claims payable under an auto liability policy and a group health plan. Why is Medicaid described as the payer of last resort?**

A. Medicaid pays first and then bills the other insurers

B. By law, all other available third parties must meet their legal obligation to pay claims before Medicaid pays

C. Medicaid splits every claim 50/50 with any other insurer

D. Medicaid only pays claims submitted in the last month of the year

**663. For Social Security disability benefits, how severe and long-lasting must a worker's impairment be?**

A. It must prevent any substantial gainful activity and be expected to last at least 12 continuous months or result in death

B. It must prevent the worker's own occupation for at least 6 months

C. It must prevent any work for at least 90 days

D. Any doctor-certified illness qualifies regardless of duration

**664. A worker is approved for Social Security Disability Insurance. How does the statutory waiting period affect when benefit payments begin?**

A. Payments begin the day after the disability onset date

B. Payments begin after a 12-month waiting period

C. Payments cannot begin until a waiting period of 5 consecutive calendar months of disability has passed

D. Payments are retroactive to the date the disability began, with no waiting period

**665. A 50-year-old has been receiving Social Security disability benefits. When does he become entitled to Medicare?**

A. Immediately upon SSDI approval

B. After being entitled to disability benefits for 24 months, with Medicare beginning in the 25th month

C. Only when he turns 65, like everyone else

D. After 12 months of disability benefit entitlement

**666. A claimant can no longer perform her skilled trade but could still do lighter unskilled work. Why might she qualify under her private own-occupation disability policy yet be denied Social Security disability benefits?**

A. Social Security only covers injuries that occur on the job

B. Private policies never consider occupation

C. Social Security pays only for disabilities lasting less than a year

D. Social Security requires inability to engage in any substantial gainful activity, a stricter test than inability to perform one's own occupation

**667. An employee receives $3,000 per month under her employer's group long-term disability plan and is then awarded $1,400 per month in Social Security disability benefits. Under a typical group LTD contract, what happens?**

A. Her Social Security benefit is reduced by the LTD amount

B. Both benefits are suspended pending review

C. The LTD benefit is offset dollar for dollar, dropping to $1,600 so her total income stays at $3,000

D. She keeps both payments in full, for $4,400 per month

**668. Marta, age 66, is still working and remains covered by her employer's high deductible health plan. She enrolls in Medicare Part A. What effect does her Medicare enrollment have on her Health Savings Account?**

A. None, as long as she keeps her HDHP coverage she may continue contributing

B. She can no longer make HSA contributions, but she may still spend her existing HSA balance on qualified medical expenses

C. Her HSA is automatically closed and the balance is refunded as taxable income

D. She must transfer the HSA balance into a Medicare Medical Savings Account within 60 days

**669. Health Savings Accounts are often described as having a "triple tax advantage." Which combination correctly describes it?**

A. Contributions are taxable, but earnings and all withdrawals are tax free

B. Contributions are deductible, earnings are taxable annually, and qualified withdrawals are tax free

C. Contributions are deductible, earnings grow tax free, and distributions for qualified medical expenses are tax free

D. Contributions are deductible, earnings grow tax free, and all withdrawals for any purpose are tax free

**670. A 68-year-old retiree withdraws money from his HSA to pay for a cruise. How is the withdrawal treated for federal tax purposes?**

A. It is included in his gross income, but no 20% additional tax applies because he is over age 65

B. It is completely tax free because he is over age 65

C. It is included in income and also subject to the 20% additional tax

D. It is tax free up to his lifetime contribution total and taxable above that

**671. An employee contributes to a health flexible spending arrangement (FSA) through salary reduction but has money left in the account at the end of the plan year. What generally happens to the unused balance?**

A. It is automatically refunded to the employee as taxable wages

B. It rolls over in full to the next plan year in every FSA

C. It converts to an HSA balance owned by the employee

D. It is generally forfeited, unless the plan offers a limited carryover or grace period

**672. Which statement about funding a health reimbursement arrangement (HRA) is correct?**

A. Employees fund the HRA through pre-tax salary reduction

B. The HRA must be funded solely by the employer; employees may not contribute

C. Employer and employee must each fund half of the annual amount

D. The HRA is funded by the health insurer out of premium refunds

**673. An insured paid all the premiums for her own disability income policy with after-tax dollars, while her coworker's identical benefits come from a plan fully paid by their employer. When both become disabled, how do their benefits compare for federal income tax purposes?**

A. Both sets of benefits are fully taxable

B. Both sets of benefits are received income tax free

C. Her benefits are tax free, while the coworker's employer-paid benefits are taxable income

D. Her benefits are taxable, while the coworker's benefits are tax free

**674. Which of the following taxpayers may claim the self-employed health insurance deduction for premiums paid on their own coverage?**

A. A W-2 employee whose employer pays no part of the premium

B. Any taxpayer who buys individual coverage on a public exchange

C. A shareholder owning 1% of a C corporation's stock

D. A more-than-2% S corporation shareholder who received wages from the corporation

**675. Who actually issues and administers Medicare Part D prescription drug plans?**

A. Insurance companies and other private companies approved by Medicare

B. The federal government directly, through Social Security offices

C. State Medicaid agencies under federal contract

D. Hospitals participating in Medicare Part A

**676. How is the Medicare Part D late enrollment penalty calculated for a beneficiary who went without creditable drug coverage for 63 or more consecutive days?**

A. A flat one-time fee equal to three months of premium

B. 1% of the national base beneficiary premium for each full uncovered month, added to the premium for as long as the person has Medicare drug coverage

C. 10% of the plan's own premium for each uncovered year, charged for twice the number of years without coverage

D. 5% of the national base beneficiary premium for each uncovered quarter, charged for five years

**677. Beginning in 2025, what major cost protection applies to Medicare beneficiaries' out-of-pocket spending on covered Part D prescription drugs?**

A. All generic drugs became free at the pharmacy

B. Premiums were capped at $35 per month for every Part D plan

C. An annual cap on out-of-pocket costs for covered drugs, set at $2,000 for 2025 and indexed in later years

D. Deductibles were eliminated from all Part D plans

**678. A Part D enrollee's medication sits on her plan's non-preferred tier with a high copayment, and her doctor states there is a medical reason she needs that specific drug. What can she request from the plan?**

A. A premium refund equal to the extra copayments

B. An automatic switch of the drug to the generic tier for all plan members

C. Retroactive reimbursement from Medicare rather than the plan

D. A tiering exception, asking the plan to charge the lower cost-sharing amount, supported by her prescriber's statement

**679. An employer's group health plan qualifies as "creditable" prescription drug coverage for Medicare purposes when it meets which standard?**

A. It is expected to pay, on average, at least as much as standard Medicare prescription drug coverage

B. It covers at least 100 brand-name drugs on its formulary

C. It charges premiums no higher than the national base beneficiary premium

D. It has been in force for at least 24 continuous months

**680. Since the Affordable Care Act took effect, how does health-status underwriting differ between individual major medical insurance and individual disability income or long-term care insurance?**

A. All three lines are now guaranteed issue with no health questions

B. Major medical plans can no longer reject applicants or charge more for health conditions, but disability income and long-term care insurers may still underwrite an applicant's health

C. Disability and long-term care policies are guaranteed issue, while major medical is fully underwritten

D. Health-status underwriting is prohibited in every line of insurance under federal law

**681. An insured stops taking basic care of a minor health problem, figuring that if it worsens his insurance will pay for treatment anyway. This careless indifference caused by the existence of coverage is best described as what?**

A. Adverse selection

B. Moral hazard

C. Morale hazard

D. Speculative risk

**682. Which insurer practice is used specifically to limit adverse selection in health insurance?**

A. Paying claims by assignment of benefits

B. Offering premium discounts for automatic bank drafts

C. Advertising during open enrollment season

D. Restricting enrollment to defined enrollment periods and applying probationary waiting periods

**683. What is the primary function of the MIB (Medical Information Bureau) in health and life insurance underwriting?**

A. It lets member insurers exchange coded underwriting information so misrepresentations on applications can be detected

B. It maintains complete copies of applicants' medical records for insurers to review

C. It approves or denies claims on behalf of member insurers

D. It sets the premium rates that member insurers must charge

**684. Why is the producer who completes a health insurance application often called the "field underwriter"?**

A. The producer sets the final premium in the field before submitting the application

B. The producer is the company's first source of risk information, accurately recording answers and observations about the applicant

C. The producer must physically examine the applicant before coverage is issued

D. The producer has authority to reject applications on the insurer's behalf

**685. A roofer and an accountant, both healthy 35-year-olds, apply to the same insurer for individual disability income coverage. Why might the roofer pay a higher premium or be offered a shorter benefit period?**

A. Disability insurers must charge everyone in a state the same rate

B. Disability underwriting ignores occupation and considers only medical history

C. Disability insurers assign applicants to occupational classes, and more hazardous occupations are rated less favorably

D. Federal law requires manual laborers to buy coverage through group plans only

**686. A hospital indemnity policy pays the insured a flat $200 for each day she is hospitalized, regardless of what the hospital actually charges. Which benefit approach does this illustrate?**

A. The indemnity (fixed cash benefit) approach

B. The expense-incurred approach

C. The service (prepaid) approach

D. The coordination of benefits approach

**687. An insured has a major medical policy with a $1,000 calendar-year deductible and 80/20 coinsurance. He incurs $5,000 of covered charges, his first claim of the year. How much does the insured pay in total?**

A. $1,000

B. $4,000

C. $2,000

D. $1,800

**688. A major medical policy contains a stop-loss provision. What happens once the insured's out-of-pocket payments reach the stop-loss limit during the year?**

A. The policy terminates for the remainder of the year

B. The insurer pays 100% of covered expenses for the rest of the benefit period

C. The deductible doubles for all later claims that year

D. The insured must switch to a network provider to keep coverage

**689. A health policy reimburses surgeon fees on a "usual, customary, and reasonable" basis. What does this mean for a claim?**

A. The insurer pays whatever amount the surgeon bills

B. The insurer pays a flat scheduled amount fixed at policy issue for every procedure

C. Payment is based on the prevailing charge for the same procedure by similar providers in the same geographic area

D. Payment equals the Medicare-approved amount for the procedure

**690. A health policy defines covered sickness as illness "first manifesting itself while the policy is in force." A condition that produced symptoms and treatment before the effective date later flares up. How is the flare-up treated under that definition?**

A. It does not qualify as a covered sickness because the illness first manifested before coverage began

B. It is covered as an accidental bodily injury instead

C. It is covered in full because the flare-up occurred during the policy period

D. It is covered only if the insured was hospitalized before the effective date

**691. A husband and wife each have group coverage through their own employers, and each is also enrolled as a dependent on the other's plan. When the wife has surgery, which plan pays her claim first?**

A. The husband's plan, because dependents' claims always go to the spouse's plan

B. Her own employer's plan, because a plan covering a person as an employee is primary over a plan covering her as a dependent

C. The plan with the lower deductible

D. Each plan pays exactly half of the claim

**692. A child's father was born March 3, 1980, and the child's mother was born January 20, 1990. The married parents live together and each covers the child under a group plan. Under the birthday rule, whose plan is primary for the child?**

A. The father's plan, because he is older

B. The plan that has covered the child the shortest time

C. The mother's plan, because January 20 falls earlier in the calendar year; the year of birth is ignored

D. Whichever plan the parents designate on the claim form

**693. Divorced parents each cover their child under separate group health plans. No court decree assigns responsibility for the child's health expenses. Under standard coordination of benefits rules, which plan pays the child's claims first?**

A. The plan of the parent with the earlier birthday in the year

B. The non-custodial parent's plan

C. The plan that has covered the child longer

D. The plan of the custodial parent

**694. Which statement best describes the purpose of a subrogation provision in a health insurance policy?**

A. It lets the insurer recover its claim payments from a third party who caused the loss, preventing the insured from collecting twice

B. It allows the insured to transfer the policy to another family member

C. It permits the insurer to raise premiums after a large claim

D. It requires the insured to exhaust government benefits before filing a claim

**695. A health plan requires advance approval before a planned, non-emergency hospital admission, and then has a nurse monitor the case while the patient is hospitalized to assess the continuing need for care. What are these two utilization review activities called, in order?**

A. Retrospective review, then subrogation

B. Precertification (prospective review), then concurrent review

C. Concurrent review, then case settlement

D. Field underwriting, then claims adjudication

**696. A 67-year-old is still working for a company with 500 employees and is covered by both the employer's group health plan and Medicare. When she incurs medical expenses, which coverage pays first?**

A. Medicare pays first because she is over 65

B. The two coverages split every claim equally

C. The employer's group health plan pays first, and Medicare pays second

D. She must choose one payer and drop the other

# National - Property & Casualty Insurance (390 questions)

**697. What is property insurance?**

A. Insurance that covers the insured's legal liability for damage to others' property
B. Insurance that protects physical property against damage or loss
C. Insurance that pays a fixed amount based on the market value of real estate
D. Insurance that indemnifies lenders when a borrower defaults on a mortgage loan

**698. What is casualty insurance?**

A. Insurance covering damage to the insured's own buildings and personal property
B. Insurance covering financial loss from the death or disability of a key employee
C. Insurance covering legal liability for injuries or damage caused to others
D. Insurance covering loss of business income when operations are suspended by a fire

**699. What is 'actual cash value' (ACV)?**

A. The policy's face value
B. The market value of stocks
C. The full cost to replace an item new
D. Replacement cost minus depreciation

**700. What is 'replacement cost' coverage?**

A. Coverage that pays to replace damaged property with new items of like kind and quality
B. Coverage that pays the current market value of damaged property less depreciation
C. Coverage that pays the original purchase price of damaged property regardless of age
D. Coverage that pays an agreed amount fixed at policy issue regardless of actual value

**701. What is a 'peril' in insurance?**

A. A condition that increases the chance of a loss occurring
B. A specific cause of loss that may trigger a claim
C. The uncertainty that a financial loss will occur
D. The financial harm that results from a covered event

**702. What is a 'named perils' policy?**

A. A policy that covers every peril except those listed
B. A policy that covers listed perils and any similar ones
C. A policy that covers only specifically listed perils
D. A policy that covers only items listed on a schedule

**703. What is an 'open perils' (all-risk) policy?**

A. A policy covering the causes of loss that are specifically listed in the form
B. A policy covering every cause of loss with no exclusions of any kind
C. A policy covering all causes of loss up to an unlimited amount with no deductible
D. A policy covering all causes of loss except those specifically excluded

**704. What is 'indemnification' in insurance?**

A. Restoring the insured to their pre-loss financial condition
B. Paying the insured the full policy limit after any covered loss
C. Recovering the claim payment from the party who caused the loss
D. Placing the insured in a better financial position than before

**705. What is 'coinsurance' in property insurance?**

A. The insured's share of a claim
B. A requirement to insure property to a minimum percentage of its value
C. Insurance from two sources
D. Sharing coverage with another company

**706. What happens if a property owner fails to meet the coinsurance requirement?**

A. The insurer may void the policy and return all premiums paid
B. The claim is paid in full but the premium increases at renewal
C. The owner becomes a coinsurer and may not receive full claim payment
D. The insurer pays the full loss, then bills the owner the shortfall

**707. What is an 'endorsement' or 'rider' in property insurance?**

A. A document that summarizes the coverage before the policy is issued
B. A document that confirms the insurer has received a claim
C. A document that transfers the policy to a new owner
D. A document that modifies or adds to the original policy

**708. What is a 'floater' policy?**

A. Coverage for property that moves from location to location
B. Insurance for boats only
C. A policy with no set premium
D. Insurance for swimming pools

**709. What is 'ordinance or law' coverage?**

A. Coverage for fines and penalties imposed for violating building codes
B. Coverage for costs to comply with building codes when repairing or rebuilding
C. Coverage for defense costs when the insured is sued over a code violation
D. Coverage for property confiscated or seized by a government authority

**710. What is 'bodily injury liability'?**

A. Coverage for your own injuries regardless of who was at fault
B. Coverage for injuries to your employees while on the job
C. Coverage for legal liability when you injure someone else
D. Coverage for damage you cause to another person's property

**711. What is 'property damage liability'?**

A. Coverage for damage to your own vehicle when you collide with another object
B. Coverage for damage to your property caused by another person
C. Coverage for injuries you cause to other people in an accident
D. Coverage for legal liability when you damage someone else's property

**712. What is 'personal liability' coverage in a homeowners policy?**

A. Coverage protecting against claims of bodily injury or property damage caused by the insured
B. Coverage paying the insured's own medical bills after an injury on the residence premises
C. Coverage paying for the insured's personal property both on and away from the premises
D. Coverage protecting the insured against liability claims arising from business conducted at the home

**713. What is an 'umbrella' liability policy?**

A. Primary liability coverage that replaces auto and homeowners policies
B. Excess liability coverage above underlying primary policies
C. A package policy that combines property and liability coverage
D. Excess property coverage above the limits of a homeowners policy

**714. What is 'negligence'?**

A. Deliberate conduct intended to cause harm to another person
B. Failure to disclose a known material fact on an insurance application
C. Failure to exercise reasonable care, resulting in harm to others
D. Failure to comply with the conditions of an insurance contract

**715. What are the elements required to prove negligence?**

A. Offer, acceptance, consideration, and legality
B. Intent, motive, opportunity, and resulting injury
C. Duty, breach of duty, foreseeability, and intent

D. Duty, breach of duty, proximate cause, and damages

**716. What does 'liability' coverage in auto insurance protect?**

A. Claims from others you injure or whose property you damage
B. Damage to your own vehicle from a collision with another car
C. Your own medical expenses after an accident regardless of fault
D. Your injuries caused by a driver who carries no insurance

**717. What is 'collision' coverage?**

A. Coverage for damage to another driver's vehicle when you are legally at fault
B. Coverage for damage to your vehicle from colliding with another object
C. Coverage for damage to your vehicle from theft, fire, or hail
D. Coverage for injuries to occupants of your vehicle in a collision

**718. What is 'comprehensive' coverage in auto insurance?**

A. Coverage for damage to your vehicle when it strikes another vehicle or object
B. Coverage for all damage to your vehicle including mechanical breakdowns
C. Coverage for damage from non-collision events like theft, fire, or hail
D. Coverage for bodily injury and property damage you cause to others

**719. What is 'uninsured motorist' (UM) coverage?**

A. Coverage for unlicensed drivers
B. Coverage for rental cars
C. Coverage for driving without insurance
D. Coverage for injuries caused by a driver who has no insurance

**720. What is 'underinsured motorist' (UIM) coverage?**

A. Coverage when the at-fault driver's insurance is insufficient to cover your damages
B. Coverage when the at-fault driver has no liability insurance or flees the scene
C. Coverage when your own liability limits are too low to pay a judgment against you
D. Coverage when your own policy limits are too low to repair your vehicle after a collision

**721. What is 'medical payments' (MedPay) coverage in auto insurance?**

A. Coverage that pays medical bills for people you injure when you are at fault
B. Coverage that pays medical bills for you and passengers regardless of fault
C. Coverage that pays medical bills, lost wages, and replacement services regardless of fault
D. Coverage that pays medical bills for you and passengers up to the state-required liability limit

**722. What is 'personal injury protection' (PIP)?**

A. Liability coverage for injuries the insured negligently causes to other people
B. Coverage for the insured's medical bills that excludes lost wages
C. No-fault coverage for medical expenses, lost wages, and other costs
D. Coverage that pays after the other driver is proven to be at fault

**723. What is a 'no-fault' auto insurance state?**

A. A state where the at-fault driver's insurer must pay every party's injury and vehicle losses in full
B. A state where injured drivers may sue the at-fault party for any amount without any threshold or limit
C. A state where each driver's own insurance pays all vehicle damage but injury claims are settled by fault
D. A state where each driver's own insurance pays their injury and related economic losses regardless of fault

**724. What are the main coverages in a homeowners policy?**

A. Dwelling, other structures, personal property, loss of use, liability, and medical payments
B. Dwelling, personal property, collision, comprehensive, liability, and uninsured motorist
C. Dwelling, other structures, personal property, loss of use, flood, and earthquake
D. Dwelling, other structures, personal property, loss of use, liability, and workers compensation

**725. What does 'dwelling coverage' (Coverage A) protect?**

A. The home's structure plus any detached buildings on the lot
B. The structure of your home and attached structures
C. Your furniture, clothing, and other contents of the home
D. The land under the home and its landscaping

**726. What does 'other structures' coverage (Coverage B) protect?**

A. Structures attached to the dwelling like an attached garage or deck
B. Structures on your property that are rented to others or used for a business
C. Detached structures on your property like fences, sheds, or detached garages
D. Personal property stored in outbuildings like sheds or detached garages

**727. What does 'personal property' coverage (Coverage C) protect?**

A. Your belongings while they are inside the home
B. Your belongings and any motor vehicles kept at home
C. Your belongings and the building's fixtures
D. Your belongings both at home and while traveling

**728. What is 'loss of use' coverage (Coverage D)?**

A. Coverage for additional living expenses if your home is uninhabitable
B. Coverage for lost business income if your home office is damaged
C. Coverage for the mortgage payments due while your home is being repaired
D. Coverage for the loss in market value of your home after a covered loss

**729. What is an HO-3 policy?**

A. The broad form homeowners policy with named-peril coverage for the dwelling and personal property
B. The most common homeowners policy with open-peril dwelling and named-peril personal property coverage
C. The comprehensive homeowners policy with open-peril coverage for the dwelling and personal property
D. The modified coverage homeowners policy with basic named perils and actual cash value settlement

**730. What is an HO-4 policy?**

A. A unit-owners policy for condominium owners
B. A broad form policy for homeowners
C. A renter's insurance policy for tenants
D. A policy for older or historic homes

**731. What is an HO-6 policy?**

A. A policy for manufactured homes
B. A farm insurance policy
C. A basic homeowners policy
D. A condo owners policy

**732. What is a 'Business Owners Policy' (BOP)?**

A. A package policy combining property and liability coverage for small businesses
B. A liability policy covering claims against a business's directors and officers
C. A policy that insures the personal assets of a sole proprietor against business creditors
D. A monoline policy providing commercial property coverage alone for a small business

**733. What is 'business interruption' insurance?**

A. Coverage for the cost to repair damaged buildings and equipment after a fire
B. Coverage for lost income and expenses when business operations are suspended
C. Coverage for lost income when a business closes due to poor sales or bankruptcy
D. Coverage for wages owed to employees who are laid off after the business closes

**734. What is 'general liability' insurance for businesses?**

A. Coverage protecting against claims of professional errors and omissions
B. Coverage protecting against injuries suffered by the business's own employees
C. Coverage protecting against third-party claims of bodily injury or property damage

D. Coverage protecting the business's own buildings and contents against damage

**735. What is 'professional liability' insurance?**

A. Coverage for bodily injury or property damage occurring at the professional's office
B. Coverage for a professional's own injuries suffered while on the job
C. Coverage for the loss of a professional's license or certification
D. Coverage for claims arising from professional errors, omissions, or negligence

**736. What is 'workers compensation' insurance?**

A. Coverage for employees injured on the job, regardless of fault
B. Coverage for employees injured on the job when the employer is proven negligent
C. Coverage for employers sued by employees for wrongful termination
D. Coverage for lost wages when an employee is laid off or furloughed

**737. Is workers compensation insurance required?**

A. No, it's optional in every state unless the employer elects coverage
B. Yes, it's mandatory in most states for employers with employees
C. Yes, it's required in every state for employers with 50 or more employees
D. Yes, it's required by federal law for every employer nationwide

**738. What is the insured's first duty after a loss?**

A. File a sworn proof of loss before any other action
B. Obtain repair estimates from at least two contractors
C. Promptly notify the insurance company of the loss
D. Begin permanent repairs to restore the property

**739. What is a 'proof of loss'?**

A. A report prepared by the adjuster estimating the amount of damage
B. A written notice from the insurer acknowledging that a claim was filed
C. A police or fire department report confirming the loss occurred
D. A formal sworn statement from the insured documenting the loss

**740. What is the purpose of a claims adjuster?**

A. To investigate claims and determine the amount the insurer should pay
B. To adjust premiums and coverage limits at each policy renewal
C. To decide whether an applicant meets the insurer's underwriting standards
D. To approve or deny claims on behalf of the state insurance department

**741. What is 'salvage' in property claims?**

A. Damaged property the insured is required to keep and repair at their own expense after a partial claim payment
B. Damaged property the insurer takes over after paying a loss, which it may sell to reduce the net cost
C. The insurer's right to recover its claim payment from the third party who caused the loss
D. The amount by which a claim payment is reduced for depreciation on damaged property

**742. What is 'subrogation' in property and casualty insurance?**

A. The insured's right to sue the insurer for an unreasonable claim denial
B. The insurer's right to take over damaged property after paying a total loss
C. The insurer's right to pursue recovery from the party responsible for the loss
D. The insurer's right to cancel the policy after paying a large claim

**743. What is 'fraud' in insurance?**

A. Unintentional misstatement of a material fact on an application
B. Failure to disclose a fact the applicant did not know was material
C. Purchasing coverage from several insurers on the same property
D. Intentional deception to obtain insurance benefits illegally

**744. What is 'arson' as it relates to property insurance?**

A. The intentional and malicious burning of property
B. The accidental burning of property through carelessness
C. The burning of property caused by an electrical fault
D. The spontaneous combustion of stored materials

**745. What is the 'duty to defend' in liability insurance?**

A. The insurer's obligation to pay damages once a judgment is entered
B. The insurer's obligation to provide legal defense for covered claims
C. The insured's obligation to cooperate with the insurer in a lawsuit
D. The insurer's obligation to defend the insured after policy limits are exhausted

**746. What is 'bad faith' in insurance?**

A. An insured's failure to disclose material facts on an application
B. An insured's intentional deception to obtain benefits illegally
C. An insurer's unreasonable denial or delay of legitimate claims
D. An insurer's cancellation of a policy for nonpayment of premium

**747. What is 'builders risk' insurance?**

A. Liability coverage for a contractor's faulty workmanship after the job is finished
B. Workers' compensation coverage for employees injured at a construction site
C. Coverage for buildings under construction against damage or loss
D. A surety bond guaranteeing the builder will complete the project on schedule

**748. What is 'inland marine' insurance?**

A. Coverage for ships, their cargo, and freight charges while at sea
B. Coverage for a business's building and its contents at a fixed location
C. Liability coverage for pleasure boats operated on inland lakes and rivers
D. Coverage for goods in transit and movable property on land

**749. What is 'ocean marine' insurance?**

A. Coverage for ships, cargo, and related maritime exposures
B. Flood insurance for coastal areas
C. Coverage for marine animals
D. Insurance for ocean-view properties

**750. What is 'directors and officers' (D&O) liability insurance?**

A. Coverage protecting the corporation itself against bodily injury claims arising on its business premises
B. Coverage protecting corporate directors and officers from personal liability for decisions
C. Coverage protecting employee benefit plan trustees from claims of plan mismanagement
D. Coverage protecting employers from claims of discrimination or wrongful termination

**751. What is 'employment practices liability' (EPL) insurance?**

A. Protection against claims of mismanagement against a company's directors and officers
B. Protection paying medical and wage benefits to employees injured on the job
C. Protection against claims of wrongful employment practices like harassment or discrimination
D. Protection against claims that an employee benefit plan was administered negligently

**752. What is 'cyber liability' insurance?**

A. Coverage for physical damage to computers and servers from fire or theft
B. Coverage for a software developer's errors in the products it designs
C. Coverage for the theft of cash and securities by a dishonest employee
D. Coverage for data breaches, cyberattacks, and related exposures

**753. What is 'garage liability' insurance?**

A. Liability coverage for businesses that service, sell, or store vehicles
B. Physical damage coverage for customers' vehicles left in the insured's care
C. Liability coverage for a homeowner's detached garage and other structures

D. Liability coverage for businesses that haul goods or passengers for hire

**754. What is 'products liability' insurance?**

A. Coverage for the cost of withdrawing a defective product from the market before anyone is hurt
B. Coverage for claims arising from injuries or damage caused by products sold or manufactured
C. Coverage for damage to the insured's own inventory while it is stored in the warehouse
D. Coverage for claims arising from injuries occurring on the insured's premises during business hours

**755. What is 'completed operations' liability?**

A. Coverage for liability arising from work while it is still in progress at a job site
B. Coverage for the cost of redoing the insured's own defective work
C. Coverage for liability arising from work after it has been completed
D. Coverage for injuries to the insured's employees while finishing a job

**756. What is 'bailee' coverage?**

A. Coverage for the insured's own property while it is loaned to another party
B. A surety bond guaranteeing a defendant will appear in court when required
C. Coverage for a landlord's liability for injuries to tenants on the premises
D. Coverage for damage to property in someone's care, custody, or control

**757. What is a 'surety bond'?**

A. A three-party agreement guaranteeing one party will fulfill an obligation to another
B. A two-party contract in which an insurer agrees to pay for losses in exchange for a premium
C. A debt instrument issued by an insurer to raise capital from outside investors
D. A reinsurance treaty transferring part of an insurer's risk to a second insurer

**758. What is a 'fidelity bond'?**

A. A guarantee that a contractor will complete a construction project
B. Coverage protecting against employee dishonesty and theft
C. A bond for faithful employees
D. A marriage-related insurance product

**759. What is the 'National Flood Insurance Program' (NFIP)?**

A. A state-run residual market pool that writes flood coverage for rejected applicants
B. A federal program reimbursing private insurers for catastrophic hurricane losses
C. A federal program providing flood insurance where private coverage is limited
D. A federal grant program that pays for flood repairs without requiring a policy

**760. Is flood damage typically covered by standard homeowners policies?**

A. Yes, but limited to the dwelling coverage amount
B. Yes, if the flood is caused by a named storm
C. No, unless the home is in a designated flood zone
D. No, flood coverage requires a separate policy

**761. Is earthquake damage typically covered by standard homeowners policies?**

A. No, earthquake coverage usually requires a separate policy or endorsement
B. Yes, earthquake is a named peril on every standard homeowners form
C. No, earthquake damage is covered under commercial property forms instead
D. Yes, but the policy applies a separate percentage deductible to earthquake losses

**762. What is the 'attractive nuisance' doctrine?**

A. Liability for injuries to adult trespassers who ignore posted warning signs
B. Liability for injuries to children attracted to dangerous conditions on property
C. Liability imposed on a business for the negligent acts of its employees
D. Liability for injuries to invited guests caused by hazards the owner failed to repair

**763. What is 'vicarious liability'?**

A. Liability imposed without any proof of negligence or fault
B. Liability that allows each defendant to be held for the full judgment
C. Liability imposed on one party for the actions of another
D. Liability of a property owner for injuries to children lured by hazards

**764. What is 'strict liability'?**

A. Liability imposed on an employer for an employee's negligent acts
B. Liability that is reduced by the injured party's own share of fault
C. Liability that requires the plaintiff to prove a breach of duty
D. Liability imposed without proof of negligence or fault

**765. What is 'joint and several liability'?**

A. Each defendant can be held responsible for the full amount of damages
B. Each defendant is responsible for damages strictly in proportion to its share of fault
C. Each defendant is responsible for an equal share of the damages regardless of fault
D. The plaintiff must sue every defendant together before collecting any damages

**766. What is 'comparative negligence'?**

A. A system where any fault by the plaintiff completely bars recovery of damages
B. A system where damages are reduced by the plaintiff's percentage of fault
C. A system where damages are divided equally among all negligent defendants
D. A system where the defendant is liable regardless of whether negligence is proven

**767. What is 'contributory negligence'?**

A. A rule that reduces the plaintiff's award in proportion to their percentage of fault
B. A defense that bars recovery when the plaintiff was more than 50 percent at fault
C. A defense that bars recovery if the plaintiff contributed to their own injury at all
D. A defense that shifts the entire loss to the defendant who contributed most to the injury

**768. What is an 'aggregate limit' in liability insurance?**

A. The maximum amount the insurer will pay for all claims arising from a single event
B. The maximum amount the insured must pay out of pocket before coverage responds
C. The total of the limits carried under all of the insured's liability policies combined
D. The maximum amount the insurer will pay for all claims during a policy period

**769. What is a 'per occurrence' limit?**

A. The maximum amount payable for any single covered event
B. The maximum amount payable to any one injured person per event
C. The maximum amount payable for all claims during the policy term
D. The amount the insured must pay before the insurer pays on each claim

**770. What is 'claims-made' coverage?**

A. Coverage that applies when the injury occurs during the policy period
B. Coverage that applies when a claim is made during the policy period
C. Coverage that applies to any claim reported after the policy has expired
D. Coverage that applies to injuries occurring before the policy's retroactive date

**771. What is 'occurrence' coverage?**

A. Coverage that applies when the claim is first made during the policy period
B. Coverage that applies if the incident is reported before the policy expires
C. Coverage that applies when the incident occurs during the policy period
D. Coverage that applies to incidents occurring after the policy's retroactive date

**772. What is a 'tail' or 'extended reporting period' endorsement?**

A. An extension of the policy period that keeps the policy in force for an added premium
B. A provision that covers incidents occurring before the policy's retroactive date
C. An endorsement allowing an occurrence policy to be converted into a claims-made form

D. An extension allowing claims to be reported after a claims-made policy expires

**773. What is 'SR-22' in auto insurance?**

A. A certificate proving minimum liability coverage, required after certain violations
B. A form filed by the insurer to cancel a policy for nonpayment of premium
C. A certificate proving a driver has completed a state-approved defensive driving course
D. A federal filing required for commercial trucks that cross state lines

**774. What is 'gap' insurance in auto coverage?**

A. Coverage paying the difference between a car's ACV and its replacement cost
B. Coverage paying the difference between a car's ACV and the loan balance
C. Coverage paying the deductible when the insured is not at fault for the loss
D. Coverage paying for a substitute vehicle while the insured's car is repaired

**775. What is the purpose of 'rental reimbursement' coverage?**

A. Paying for damage you cause to a rental car while driving it on vacation
B. Paying the balance owed on a lease when a rented vehicle is declared a total loss
C. Paying for a rental car while your vehicle is being repaired after a covered loss
D. Paying for towing and roadside labor when your vehicle breaks down away from home

**776. What is 'towing and labor' coverage?**

A. Coverage for mechanical repairs performed at a shop after the vehicle breaks down
B. Coverage for a rental vehicle while the insured's car is out of service
C. Liability coverage for a tow truck operator who damages a customer's vehicle
D. Coverage for towing costs and minor roadside labor like flat tire changes

**777. What is 'blanket coverage' in property insurance?**

A. A single coverage amount applying to multiple properties or items
B. A separate coverage amount stated for each building or item on the schedule
C. Coverage written on an open-perils basis for all property at one location
D. A coverage amount that rises automatically each year to keep pace with inflation

**778. What is 'valued policy' law?**

A. State laws requiring insurers to pay actual cash value regardless of the policy limit
B. State laws requiring insurers to pay the full policy limit for total losses
C. State laws requiring insureds to carry coverage equal to a percentage of property value
D. State laws requiring insurers to reappraise insured property each time a policy renews

**779. What is 'extra expense' coverage?**

A. Coverage for the net income a business loses while its premises are being restored
B. Coverage for costs that exceed the policy limit on a large property loss
C. Coverage for additional costs to continue operations after a covered loss
D. Coverage for additional costs of rebuilding to meet current building codes

**780. An auto repair shop wants coverage for damage to customers' vehicles left with it for service - a fire in the shop, theft from the lot, or a test-drive accident. Which coverage responds?**

A. Garage liability coverage
B. Commercial property coverage
C. Garagekeepers coverage
D. The customers' own collision coverage

**781. A fire damages a building down the street, and the fire department closes the whole block for a week. An undamaged bakery on the block loses a week of sales. Which business income extension may pay for that loss?**

A. Civil authority coverage
B. Builders risk insurance
C. Equipment breakdown coverage
D. Ordinance or law coverage

**782. What is 'errors and omissions' (E&O) insurance?**

A. General liability coverage for bodily injury occurring on a professional's premises
B. Professional liability coverage for mistakes or failures in professional services
C. Coverage for a company's directors and officers against claims of mismanagement
D. Fidelity coverage for losses caused by the dishonest acts of a professional's employees

**783. A consultant's professional liability insurer recommends settling a claim for $50,000, but the consultant refuses consent. What does the policy's 'hammer clause' mean for the consultant?**

A. The insurer must keep defending with no limit on its obligation
B. The insurer's liability may be capped at the $50,000 it could have settled for, plus defense costs incurred to that point
C. The claim is automatically referred to binding arbitration
D. The consultant immediately forfeits all coverage

**784. Many professional liability policies pay defense costs 'inside' the policy limit. What does that mean?**

A. The insurer defends only lawsuits filed during the policy period
B. Defense is handled by the insurer's in-house attorneys
C. Legal defense expenses reduce the limit left to pay settlements or judgments
D. Defense costs are unlimited as long as the case continues

**785. What is 'fiduciary liability' insurance?**

A. Coverage for those managing employee benefit plans against claims of mismanagement
B. Trust fund protection
C. Insurance for trustees
D. Financial advisor insurance

**786. Unlike a CGL insurer's duty to defend, many D&O policies operate on a reimbursement (indemnity) basis. What does that mean in practice?**

A. The insured arranges and pays for its own defense, and the insurer reimburses covered costs
B. The insurer must appoint defense counsel within 30 days
C. Only out-of-pocket medical payments are covered
D. The policy pays only after all other insurance is exhausted

**787. What is 'contingent business interruption' coverage?**

A. Coverage for income loss while the insured's own damaged premises are being restored
B. Coverage for income loss when a civil authority prohibits access to the insured's premises
C. Coverage for income loss when a key supplier's or customer's operations are disrupted
D. Coverage for extra costs to keep operating after damage to the insured's own building

**788. What is the 'products-completed operations' hazard?**

A. Liability for injury or damage arising from ongoing operations at the insured's job site
B. Liability for injury or damage occurring to customers while visiting the insured's premises
C. Liability for the cost of recalling or replacing a product that is found to be defective after sale
D. Liability for injury or damage arising from products sold or work completed away from premises

**789. What is 'premises and operations' coverage?**

A. Liability coverage for injuries or damage occurring on insured premises or from ongoing operations
B. Liability coverage for injuries or damage caused by the insured's products after they are sold
C. Property coverage for damage to the insured's own building and equipment used in its operations
D. Liability coverage for injuries or damage arising from the insured's work after it is completed

**790. What is 'personal and advertising injury' coverage?**

A. Coverage for bodily injury to customers caused by a product the insured promoted in its ads
B. Coverage for offenses like libel, slander, false arrest, and copyright infringement in advertising
C. Coverage for medical expenses and lost wages after an auto accident regardless of fault
D. Coverage for the cost of reprinting or rerunning an advertisement that contained a factual error

**791. A personal umbrella policy covers a claim that is excluded by the underlying homeowners policy but covered by the umbrella. What amount does the insured typically pay first?**

A. The full underlying policy limit
B. Nothing - the umbrella pays from the first dollar
C. A self-insured retention (SIR)
D. Double the homeowners deductible

**792. What is 'excess' liability insurance?**

A. Coverage placed with a non-admitted insurer when admitted carriers decline the risk
B. Coverage that shares each loss proportionally with the insured's primary policy
C. Coverage that broadens the terms of the underlying policy to fill gaps in protection
D. Coverage that pays only after underlying policy limits are exhausted

**793. What is 'hired and non-owned auto' coverage?**

A. Liability coverage for vehicles used for business that aren't owned by the insured
B. Physical damage coverage for vehicles the business leases under a long-term contract
C. Liability coverage for vehicles the business owns and registers in its own name
D. Liability coverage for employees' personal vehicles while driven for personal errands

**794. What is 'motor carrier' insurance?**

A. Motorcycle insurance
B. Commercial auto coverage required for businesses transporting goods or passengers for hire
C. Moving company coverage
D. Insurance for car carriers

**795. What is 'cargo' insurance?**

A. Coverage for the truck or vessel itself against physical damage while carrying goods
B. Liability coverage for a carrier's bodily injury claims arising from its delivery vehicles
C. Coverage for goods being transported against loss or damage during transit
D. Coverage for goods stored in the insured's warehouse against fire, theft, and vandalism

**796. A dry cleaner damages a customer's garment but is not legally at fault. Which form would still pay the customer?**

A. A bailee legal liability form, because the goods were in the insured's care
B. A bailees customers form, which pays regardless of the bailee's legal liability
C. The cleaner's own commercial property policy
D. No coverage applies unless the customer sues successfully

**797. What is 'pollution liability' insurance?**

A. Coverage for cleanup costs and third-party damages from pollution incidents
B. Coverage for regulatory fines and penalties assessed by the EPA for emissions violations
C. The absolute pollution exclusion that removes contamination claims from a CGL policy
D. Coverage for gradual wear and deterioration of the insured's own storage tanks and pipes

**798. What is 'contractual liability' coverage?**

A. Coverage for the insured's financial losses when the other party fails to perform a contract
B. Coverage for liability assumed under a contract that would otherwise be the other party's responsibility
C. Coverage that shifts the insured's own negligence liability onto the other party to the contract by agreement
D. Coverage for a professional's liability arising from errors in drafting contracts for clients

**799. A driver runs a red light - violating a traffic safety statute - and injures a pedestrian. The court treats the statutory violation itself as establishing the driver's breach of duty. Which doctrine is being applied?**

A. Assumption of risk
B. Negligence per se
C. Strict liability
D. Last clear chance

**800. A pedestrian is injured when a barrel rolls out of a warehouse's upper doorway - an accident that ordinarily would not happen without negligence, involving equipment solely in the warehouse operator's control. Which doctrine lets the injury itself create an inference of negligence?**

A. Res ipsa loquitur
B. Contributory negligence
C. Vicarious liability
D. Proximate cause

**801. In a bodily injury liability claim, the award for the victim's pain and suffering is classified as which type of damages?**

A. Special damages
B. Punitive damages
C. Property damages
D. General damages

**802. In a state using modified comparative negligence with a 51% bar, a jury finds the plaintiff 60% at fault for her own $100,000 injury. How much can she recover?**

A. $40,000
B. $60,000
C. Nothing
D. $100,000

**803. What is the 'assumption of risk' defense?**

A. A defense that the plaintiff's own carelessness contributed to the injury
B. A defense that too much time has passed for the plaintiff to file the lawsuit
C. A defense that the plaintiff knowingly accepted the risks of an activity
D. A defense that the defendant's act was not the proximate cause of the injury

**804. What are 'punitive damages'?**

A. Fines and penalties imposed by the state in a criminal prosecution of the defendant
B. Court costs and attorney fees awarded to the prevailing party at the end of the lawsuit
C. Compensatory damages that reimburse the plaintiff's medical bills, lost wages, and repairs
D. Damages awarded to punish the defendant for egregious conduct, not just compensate the plaintiff

**805. What is the 'statute of limitations' in insurance claims?**

A. The time period within which a legal action must be filed
B. The time period the insurer has to accept or deny a submitted claim
C. The maximum number of years a liability policy can remain in force
D. The time after a loss within which the insured must notify the insurer

**806. In a few 'monopolistic' states, where must an employer buy its workers compensation insurance?**

A. From any licensed private insurer
B. From the state's own workers compensation fund
C. From the federal government
D. From its industry trade association

**807. What is the 'exclusive remedy' doctrine in workers' compensation?**

A. The employer may purchase workers' compensation only from the state fund, not from private insurers
B. An injured employee may collect benefits only from the employer's policy, not from a negligent third party
C. Workers' compensation is the only remedy for workplace injuries, barring lawsuits against employers
D. An injured employee must choose between workers' compensation benefits and a negligence lawsuit against the employer

**808. What is 'experience modification' in workers' compensation?**

A. A factor adjusting premiums based on the number of years the employer has been in business
B. A plan adjusting the final premium after the policy period based on losses during that same period
C. A credit applied to the premium when the employer adopts a formal workplace safety program
D. A factor adjusting premiums based on an employer's actual loss history compared to expected losses

**809. What is 'retrospective rating' in workers' compensation?**

A. A rating plan where final premium is adjusted based on actual losses during the policy period
B. A rating plan where premium is adjusted based on the employer's losses during the prior three years
C. A rating plan where premium is set by the employer's payroll and industry classification code alone
D. A rating plan where premium is discounted because the policy's total standard premium is large

**810. What does 'NCCI' stand for in workers' compensation?**

A. Network of Compensation Coverage Insurers
B. National Council on Compensation Insurance
C. National Casualty Claims Institute
D. National Committee on Coverage Issues

**811. A contractor finishes building a bridge. Which bond guarantees the completed work will stay free of defects in materials and workmanship for a stated period afterward?**

A. A bid bond
B. A payment bond
C. A maintenance bond
D. A fidelity bond

**812. Appeal bonds, attachment bonds, and guardianship bonds are all examples of which category of surety bond?**

A. Contract bonds
B. License and permit bonds
C. Judicial (court) bonds
D. Public official bonds

**813. What is a 'performance bond'?**

A. A surety bond guaranteeing a contractor will complete a project according to contract terms
B. A surety bond guaranteeing a contractor will pay all subcontractors and material suppliers
C. A surety bond guaranteeing a contractor will sign the contract if it is awarded the bid
D. A surety bond guaranteeing a contractor will correct defective work for a period after completion

**814. What is a 'payment bond'?**

A. A surety bond guaranteeing the project owner will pay the contractor on schedule
B. A surety bond guaranteeing a contractor will pay subcontractors and suppliers
C. A surety bond guaranteeing a contractor will finish the project as specified
D. A surety bond guaranteeing a contractor will enter into the contract once the bid is awarded

**815. What is a 'bid bond'?**

A. A surety bond guaranteeing the contractor will complete the work according to the contract
B. A surety bond guaranteeing the owner will award the contract to the lowest responsible bidder
C. A surety bond guaranteeing a contractor will enter into a contract if awarded the bid
D. A surety bond guaranteeing the contractor will pay all subcontractors and material suppliers

**816. During a suspicious fire claim, the insurer formally requires the insured to answer questions under oath, transcribed by a reporter, as a condition of the policy. What is this process called?**

A. An examination under oath (EUO)
B. An appraisal
C. A deposition in a lawsuit
D. Arbitration

**817. In a standard homeowners policy, which coverage is primarily intended for the dwelling itself?**

A. Coverage A
B. Coverage E
C. Coverage C
D. Coverage B

**818. Which homeowners coverage usually applies to a detached garage on the residence premises?**

A. Coverage F - Medical Payments
B. Coverage B - Other Structures
C. Coverage C - Personal Property
D. Coverage A - Dwelling

**819. What is the main purpose of Coverage C in a homeowners policy?**

A. To insure detached structures such as a garage or shed
B. To insure the dwelling and structures attached to it
C. To insure personal property owned or used by an insured
D. To pay additional living expenses when the home is unfit to live in

**820. A homeowners policy includes Coverage D. What does this coverage usually address?**

A. Damage to other structures on the premises
B. Medical payments to injured guests
C. Personal liability for injury to others
D. Loss of use or additional living expense

**821. Which homeowners coverage part is most closely tied to personal liability claims against an insured?**

A. Coverage E
B. Coverage F
C. Coverage B
D. Coverage C

**822. Coverage F in a homeowners policy is commonly designed to pay which type of claim?**

A. Damage to the insured's automobile
B. Medical payments to others without requiring legal liability
C. Replacement of the insured's own roof after wear and tear
D. The insured's business payroll after a fire

**823. Which loss is commonly excluded or limited under many homeowners policies unless additional coverage is purchased?**

A. Smoke damage from a covered fire
B. Fire damage to covered property
C. Flood damage from rising water
D. Wind damage to the dwelling

**824. A scheduled personal property endorsement is most often used to do what?**

A. Increase the Coverage C limit for all personal property in the home by a set percentage
B. Extend the dwelling coverage to a detached structure used for business
C. Add replacement cost settlement to all personal property in the home
D. Provide broader or higher-limit coverage for specifically listed valuable items

**825. Which valuation approach pays the cost to replace damaged property with new property of like kind and quality, without deducting for depreciation?**

A. Replacement cost
B. Market value only
C. Salvage value
D. Actual cash value

**826. Actual cash value is commonly described as replacement cost minus what?**

A. Liability limit
B. Depreciation
C. Premium
D. Commission

**827. In personal auto insurance, bodily injury liability coverage is primarily designed to pay for what?**

A. Injuries to the insured and passengers regardless of who is at fault
B. Damage to the insured's own vehicle from a collision
C. Injuries to others for which the insured is legally liable
D. Injuries to the insured caused by a driver who has no insurance

**828. Property damage liability in an auto policy most directly applies to which situation?**

A. The insured's car is stolen
B. The insured needs roadside assistance
C. The insured wants a lower deductible
D. The insured damages another person's vehicle in a covered accident

**829. Collision coverage in a personal auto policy generally covers which type of loss?**

A. Damage to the covered auto from impact with another vehicle or object
B. Damage to another person's vehicle that the insured strikes
C. Damage to the covered auto from hail, flood, or contact with animals
D. Bodily injury to the insured's passengers regardless of fault

**830. Comprehensive coverage in a personal auto policy is commonly associated with which type of loss?**

A. Damage from colliding with another vehicle or a fixed object
B. Damage from theft, fire, vandalism, or falling objects
C. Damage from the vehicle overturning on a slippery road
D. Damage the insured causes to another person's property

**831. Uninsured motorist coverage is generally intended to protect the insured when what happens?**

A. The insured's own liability limits are exhausted by a large claim
B. An at-fault driver has liability limits lower than the insured's damages
C. An at-fault driver has no applicable liability insurance
D. The insured is at fault in an accident and has let coverage lapse

**832. Underinsured motorist coverage is generally triggered when what is true?**

A. The at-fault driver has no liability insurance and cannot be identified after a hit and run
B. The insured's own liability limits are lower than the damages the insured caused another party
C. The at-fault driver's insurer denies the claim because the policy was cancelled for nonpayment
D. The at-fault driver has some liability insurance, but not enough to cover the insured's damages

**833. Medical payments coverage in an auto policy usually pays for what?**

A. Covered medical expenses for insured persons after an auto accident, regardless of fault
B. The insured's legal defense costs only
C. Lost business income after a fire
D. Damage to the other driver's car only

**834. A split liability limit of 100/300/50 commonly means what?**

A. $100,000 bodily injury per accident, $300,000 bodily injury per person, $50,000 property damage
B. $100,000 bodily injury per person, $300,000 bodily injury per accident, $50,000 property damage
C. $100,000 property damage per accident, $300,000 bodily injury per accident, $50,000 medical payments
D. $100,000 bodily injury per person, $300,000 property damage per accident, $50,000 aggregate per policy

**835. Which personal auto coverage is most likely to have a deductible?**

A. Bodily injury liability
B. Uninsured motorist bodily injury
C. Collision coverage
D. Property damage liability

**836. A named non-owner auto policy is most likely used for a person who does what?**

A. Owns a car but wants coverage for a named driver who is excluded from the policy
B. Owns several cars and wants one policy that names each driver rather than each vehicle
C. Uses a company-furnished vehicle and wants physical damage coverage on that vehicle

D. Does not own a car but needs personal auto liability coverage when driving non-owned autos

**837. Liability insurance primarily protects against which type of exposure?**

A. Legal responsibility for covered injury or damage to others
B. Direct physical loss to the insured's own building and contents
C. The insured's own medical bills after an accident, regardless of fault
D. Loss of the insured's income when a covered peril shuts down the business

**838. The duty to defend in a liability policy generally means the insurer may do what?**

A. Defend the insured once a court has first ruled that the claim is covered
B. Defend the insured against covered or potentially covered claims
C. Defend the insured against any lawsuit, even if the policy clearly excludes it
D. Pay the insured's chosen attorney's fees up to the policy's liability limit

**839. Which term refers to an unbroken chain of events between negligence and injury?**

A. Res ipsa loquitur
B. Intervening cause
C. Proximate cause
D. Strict liability

**840. Which element is typically required to establish negligence?**

A. A deductible
B. A covered auto only
C. A written insurance application
D. A breach of a legal duty

**841. Which type of damages is intended to compensate an injured party for actual loss?**

A. Compensatory damages
B. Symbolic damages only
C. Punitive damages
D. Speculative damages

**842. Punitive damages are generally intended to do what?**

A. Reimburse the plaintiff's medical bills, lost wages, and repair costs
B. Punish especially wrongful conduct and deter similar behavior
C. Compensate the plaintiff for pain, suffering, and loss of enjoyment of life
D. Reimburse the plaintiff's attorney fees and court costs after a verdict

**843. An aggregate limit in liability insurance is best described as what?**

A. The maximum the policy will pay for any single covered occurrence during the policy period
B. The maximum the policy will pay to any one injured person in a single covered accident
C. The total maximum the policy will pay for all covered claims during a policy period
D. The amount the insured must pay on each claim before the policy begins to pay

**844. An occurrence limit is most closely tied to which concept?**

A. The total payable for all claims during the policy period
B. The maximum payable to any one person injured in an event
C. The amount the insured retains before the policy pays
D. The maximum payable for one covered event or occurrence

**845. A personal umbrella policy is generally designed to provide what?**

A. Extra liability coverage above underlying policies
B. Broader property coverage for high-value homes
C. Primary liability coverage that replaces auto and home policies
D. Excess medical payments coverage for household members

**846. Which situation is most likely a liability claim rather than a first-party property claim?**

A. The insured's computer is stolen from home
B. The insured's guest slips on the insured's icy steps and is injured
C. The insured's garage is damaged by wind
D. The insured's roof is damaged by hail

**847. Commercial property insurance is primarily designed to cover what?**

A. The business's legal liability for injuries to customers on its premises
B. Employees' medical bills and lost wages after injuries suffered on the job
C. Business-owned buildings and business personal property against covered causes of loss
D. Business-owned vehicles, trucks, and trailers against collision and other-than-collision losses

**848. Business personal property coverage commonly applies to which item?**

A. The owner's personal vacation home only
B. The owner's private life insurance policy
C. A customer's medical expenses under health insurance
D. Inventory, furniture, and equipment owned by the business

**849. Business income coverage is generally intended to replace what after a covered property loss?**

A. Lost net income and certain continuing expenses during restoration
B. The cost to repair or rebuild the damaged building and replace its contents
C. Gross revenue the business would have earned for the full policy term
D. Extra costs incurred to keep operating at a temporary location

**850. Extra expense coverage is designed to pay which type of cost?**

A. The net income the business loses while operations are suspended after a covered loss
B. Necessary expenses to reduce or avoid a business interruption after a covered loss
C. Ordinary operating expenses the business would have incurred even without a loss
D. The increased cost to rebuild a damaged building to meet current building codes

**851. A builders risk policy is most often used to cover what?**

A. Directors and officers liability only
B. Completed medical claims
C. Property under construction
D. Private passenger auto liability

**852. A causes of loss form helps determine what?**

A. The dollar limits of insurance shown on the declarations page
B. What types of property are covered at the described premises
C. How the value of damaged property is determined at settlement
D. Which perils or causes of loss are covered or excluded

**853. A vacancy condition in commercial property insurance is important because vacancy can do what?**

A. Increase loss risk and restrict or reduce coverage under policy conditions
B. Trigger an automatic premium refund for each month the building sits unoccupied
C. Void the policy immediately on the first day the building becomes vacant
D. Shift the coinsurance requirement from the insured to the mortgageholder

**854. Coinsurance in commercial property insurance encourages the insured to do what?**

A. Share every covered loss with the insurer on a fixed percentage basis
B. Carry insurance close to the required percentage of the property's value
C. Insure the property for its full market value rather than replacement cost
D. Select the highest available deductible to keep premiums as low as possible

**855. Commercial general liability insurance is primarily designed to cover which exposure?**

A. Professional liability for errors, omissions, and negligent advice by the insured in its trade or occupation
B. Direct physical damage to the insured's own buildings, business personal property, and stock from covered perils
C. Business liability for covered bodily injury, property damage, and certain personal and advertising injury claims

D. Liability for bodily injury to the insured's own employees arising out of and in the course of their employment

**856. In a CGL policy, Coverage A most commonly applies to what?**

A. Personal and advertising injury liability
B. Medical payments regardless of fault
C. Damage to the insured's own premises and stock
D. Bodily injury and property damage liability

**857. In a CGL policy, Coverage B is commonly associated with what?**

A. Personal and advertising injury liability
B. Bodily injury and property damage liability
C. Medical payments without regard to fault
D. Products-completed operations liability

**858. In a CGL policy, Coverage C usually provides what?**

A. Medical payments for the insured's own employees injured on the premises
B. Medical payments for certain injuries without regard to legal liability
C. Defense costs for personal and advertising injury suits within the limits
D. Bodily injury damages the insured becomes legally obligated to pay to others

**859. Products-completed operations coverage is most relevant to which situation?**

A. A customer trips over stock while shopping inside the insured's store
B. A defective product must be withdrawn from the market before anyone is hurt
C. A product sold by the insured injures a customer after the sale
D. A subcontractor damages a client's floor while work is still in progress

**860. The premises and operations hazard in CGL coverage generally relates to what?**

A. Liability arising from the insured's products after they have left its hands
B. Direct damage to the insured's own building and contents at the described premises
C. Liability for injuries to the insured's employees while working on the premises
D. Liability arising from the insured's premises or ongoing business operations

**861. Which claim is most likely excluded by a standard CGL policy and handled by workers compensation instead?**

A. An employee is injured while performing job duties
B. A customer slips in the store
C. A visitor's property is damaged by negligence
D. A product injures a buyer after sale

**862. Which CGL exclusion is designed to prevent the policy from becoming a warranty for the insured's own faulty work?**

A. The annuity exclusion
B. The business risk exclusions
C. The personal auto exclusion only
D. The flood exclusion

**863. Workers compensation insurance is designed mainly to cover what?**

A. Lawsuits by customers injured on the employer's premises or by its products
B. Employee injuries that occur off the job, such as at home or on vacation
C. Job-related employee injuries or occupational disease benefits required by law
D. Employer's defense costs for wrongful termination and discrimination suits

**864. Employer's liability coverage in a workers compensation policy generally protects the employer against what?**

A. The statutory medical and wage benefits owed to injured employees under workers compensation law
B. Lawsuits by customers or other members of the public who are injured by the employer's operations
C. Claims that the employer wrongfully terminated, harassed, or discriminated against an employee
D. Certain lawsuits by employees or related parties not fully covered by workers compensation benefits

**865. A key feature of workers compensation is that benefits are generally provided based on what principle?**

A. No-fault benefits for covered work-related injuries
B. Benefits paid after the employee proves the employer was negligent
C. Benefits reduced by the employee's own percentage of fault
D. Benefits paid as damages awarded by a court against the employer

**866. Which item is commonly used in workers compensation rating?**

A. The owner's personal credit card rewards
B. Payroll by classification
C. The number of life insurance beneficiaries
D. The homeowner's roof age only

**867. An experience modification factor in workers compensation is used to reflect what?**

A. The employer's total payroll divided by the number of employees
B. The hazard level assigned to each job classification code
C. The employer's loss experience compared with similar employers
D. The years the employer has been continuously insured with the same carrier

**868. Which benefit is commonly included in workers compensation systems?**

A. Homeowners liability coverage
B. A guaranteed retirement annuity
C. Collision repair for the employee's personal car after any accident
D. Medical benefits for covered work-related injuries

**869. Inland marine insurance is often used to cover what type of property?**

A. Movable property, property in transit, or specialized property exposures
B. Cargo carried aboard vessels on the open sea and the vessels themselves
C. Permanent buildings and fixed structures at a single described premises location
D. Owned autos, hired autos, and nonowned autos used in the business

**870. A contractors equipment floater is commonly used to insure what?**

A. A contractor's liability for faulty completed work
B. Mobile tools and equipment used by a contractor
C. Vehicles the contractor drives on public highways
D. A building under construction until it is completed

**871. An accounts receivable coverage form is designed to help when what happens?**

A. A customer of the insured becomes insolvent and cannot pay an outstanding invoice
B. The insured's bookkeeper embezzles payments received from customers
C. Covered records of amounts owed to the insured are damaged or destroyed
D. The insured's records of amounts it owes to suppliers are lost in a fire

**872. A valuable papers and records form is intended to cover what?**

A. The face value of money, securities, and negotiable instruments stolen from the premises
B. Amounts the insured cannot collect because its customer billing records were destroyed
C. The insured's liability to clients whose confidential documents were exposed in a data breach
D. The cost to research, replace, or restore important documents after covered loss

**873. A transportation floater is most closely associated with which exposure?**

A. Property while being transported
B. Personal liability for libel
C. Homeowners medical payments only
D. Employee retirement income

**874. Commercial crime insurance is commonly used to cover which exposure?**

A. Liability for injuries during a robbery on the premises
B. Employee theft or certain theft-related losses
C. Losses caused by the insured's own dishonest acts
D. Damage to a customer's property in the insured's care

**875. Employee theft coverage is designed to protect an employer from what?**

A. Theft of employees' personal property at work
B. Robbery of a messenger by an outside third party
C. Covered dishonest acts committed by employees
D. Dishonest acts committed by the business owner

**876. A surety bond involves which three parties?**

A. Owner, beneficiary, annuitant
B. Insured, claimant, adjuster
C. Driver, passenger, mechanic
D. Principal, obligee, surety

**877. A performance bond generally guarantees what?**

A. A contractor will perform according to the contract
B. A contractor will pay its subcontractors and suppliers
C. A contractor will sign the contract if the bid is accepted
D. A contractor will be paid on time by the project owner

**878. A fidelity bond is most closely related to which risk?**

A. Life insurance lapse
B. Employee dishonesty
C. Auto collision
D. Earthquake damage

**879. The appraisal condition in a property policy is generally used to resolve disputes about what?**

A. The identity of a life insurance beneficiary
B. A workers compensation class code only
C. The amount of loss
D. Whether the insured is old enough for health insurance

**880. The liberalization condition generally provides what?**

A. Automatic application of any coverage restrictions the insurer adopts during the policy period without notice
B. The insured's right to request broadened coverage by endorsement upon payment of additional premium
C. A refund of unearned premium when the insurer's newly filed forms would have cost the insured less
D. Automatic application of certain coverage broadening changes without additional premium for a specified period

**881. The concealment or fraud condition generally allows the insurer to deny coverage or void coverage when what occurs?**

A. The insured intentionally misrepresents or conceals material facts
B. The insured innocently misstates an immaterial detail on the application
C. The producer withholds a material fact that is known to the insurer
D. The insured files a claim for a loss that later turns out not to be covered

**882. A deductible in property insurance is best described as what?**

A. The percentage of each covered loss the insured shares with the insurer
B. The amount the insured must absorb before the policy pays a covered loss
C. The minimum amount of insurance the insured must carry to avoid penalty
D. The most the insurer will pay for any one covered loss during the term

**883. Which loss is commonly excluded under many property policies because it is not accidental damage?**

A. Wind damage during a covered storm
B. Fire from lightning
C. Normal wear and tear
D. Smoke damage from a covered fire

**884. The insured's duties after a loss commonly include which action?**

A. Destroy damaged property before inspection in every case
B. Admit liability to every claimant immediately
C. Refuse to cooperate with the insurer
D. Give prompt notice of the loss to the insurer

**885. The other insurance condition is generally used to determine what?**

A. How coverage applies when more than one policy may cover the same loss
B. Which of two policies must be cancelled when both cover the same property
C. How the insurer recovers from a negligent third party after paying a claim
D. How a loss is split when two insureds share ownership of the same property

**886. A pair or set condition in property insurance is most relevant when what happens?**

A. An insured names two beneficiaries
B. Only part of a matched pair or set is damaged
C. Two auto policies renew on the same date
D. An employee has two jobs

**887. Which principle says the insured should be restored to the financial position held before the loss, not profit from the loss?**

A. Estoppel
B. Adhesion
C. Indemnity
D. Aleatory contract

**888. A peril is best described as what?**

A. The chance of financial loss only
B. The policy period
C. The amount of premium
D. The cause of loss

**889. A hazard is best described as what?**

A. A condition that increases the chance or severity of loss
B. The actual cause of a loss, such as fire or windstorm
C. The uncertainty about whether a loss will occur
D. The reduction in value of property because of a covered event

**890. Which example is a morale hazard?**

A. A slippery floor with no warning sign
B. Being careless because insurance is available
C. Intentionally burning property for insurance money
D. A hurricane approaching the coast

**891. Which example is a moral hazard?**

A. A building has old wiring by accident
B. A tree falls during a storm
C. An insured intentionally causes a loss to collect insurance proceeds
D. A driver buys collision coverage

**892. Which coverage part is designed for business-owned vehicles used in company operations?**

A. Personal inland marine coverage
B. Homeowners liability coverage
C. A life insurance rider
D. Commercial auto coverage

**893. In a business auto policy, covered auto symbols are mainly used to:**

A. show which categories of autos are covered for a coverage
B. identify each covered auto by its vehicle identification number
C. assign a rating classification based on vehicle size and use
D. indicate the physical damage deductible that applies to each auto

**894. A company employee uses a personal car for a work errand and causes an accident. Which exposure may the employer need to insure?**

A. ocean marine liability
B. nonowned auto liability
C. workers compensation medical-only benefits
D. equipment breakdown spoilage

**895. Hired auto coverage is generally used for vehicles that the business:**

A. uses only as employee personal property
B. owns and lists as inventory only
C. leases, rents, hires, or borrows
D. sells to customers after repairs

**896. Why might a business need both hired and nonowned auto liability coverage?**

A. to cover physical damage to vehicles the business rents for short periods
B. to protect employees' personal auto policies from being cancelled after a loss
C. to cover vehicles the business owns but has not yet listed on the schedule
D. to address rented vehicles and employee-owned vehicles used for business

**897. Physical damage coverage under a commercial auto policy generally protects against:**

A. loss to covered autos themselves
B. dishonest acts by partners only
C. injury to employees covered by workers compensation
D. loss of business income from all causes

**898. Commercial auto liability coverage primarily pays for:**

A. collision and comprehensive damage to the insured's own covered autos regardless of which driver caused the accident
B. bodily injury or property damage the insured is legally responsible for because of a covered auto accident
C. medical expenses for the insured's employees injured while driving a covered auto on company business
D. bodily injury to the insured's driver caused by an at-fault motorist who carries no liability insurance

**899. A delivery business buys only liability coverage for its trucks. Which loss is most likely NOT covered by that choice alone?**

A. collision damage to the business's own truck
B. injury to a pedestrian struck by a truck
C. damage to a parked car hit by a truck
D. attorney fees to defend a covered lawsuit

**900. Which business is most likely to need commercial auto coverage?**

A. a retiree buying a Medicare supplement
B. a renter buying personal property coverage
C. a florist that uses vans for deliveries
D. a person insuring only a private family sedan

**901. Why is the declarations page important in a commercial auto policy?**

A. it contains the exclusions and conditions that determine whether a loss is paid
B. it sets out the insurer's duty to defend and the supplementary payments provided
C. it lists every driver who is permitted to operate the covered autos under the policy
D. it shows selected coverages, limits, covered auto symbols, and insured vehicles

**902. A Businessowners Policy, or BOP, commonly combines:**

A. commercial auto and workers compensation for small employers
B. property and liability coverage for eligible small businesses
C. general liability and professional liability for service firms
D. property coverage and a personal umbrella for the business owner

**903. Why might a small retail shop choose a BOP?**

A. it includes workers compensation for the shop's employees at no added cost
B. it lets the shop choose any combination of commercial auto coverages
C. it can package common property and liability coverages in one policy
D. it provides professional liability for advice given to customers

**904. Business personal property coverage in a BOP generally protects:**

A. the building itself, including permanently installed fixtures and machinery
B. the owner's personal belongings kept at home and used occasionally for work
C. vehicles licensed for road use that are parked at the business premises
D. covered business contents such as furniture, stock, and equipment

**905. A restaurant loses income after a covered fire closes the business during repairs. Which BOP coverage may respond?**

A. business income coverage
B. employee dishonesty bond only
C. life settlement option
D. personal auto liability

**906. BOP liability coverage generally protects the insured against covered claims for:**

A. employee injuries arising in the course of employment
B. bodily injury, property damage, and personal/advertising injury
C. damage to the insured's own building, stock, and equipment
D. professional errors and omissions in services to clients

**907. Which business may be less likely to qualify for a standard BOP without special underwriting?**

A. a small retail store
B. a small office tenant
C. a high-hazard manufacturing operation
D. a neighborhood barber shop

**908. A BOP usually does not replace the need for which separate coverage?**

A. business income coverage when the premises are shut down by a covered loss
B. general liability coverage for slip-and-fall claims by customers on the premises
C. business personal property coverage for stock and equipment at the premises
D. workers compensation when employees are subject to workers compensation law

**909. The property section of a BOP is most directly concerned with:**

A. covered buildings and business personal property
B. the insured's liability to customers and guests
C. employee injuries and occupational diseases
D. the insured's owned and hired business vehicles

**910. An endorsement added to a BOP is used to:**

A. cancel the policy and issue a replacement contract
B. modify coverage, limits, conditions, or exclusions
C. restate the declarations without changing coverage
D. summarize the policy's key terms for the insured's records

**911. Why should a business review BOP exclusions carefully?**

A. exclusions are automatically waived when a claim is filed on time
B. exclusions determine the premium refund on early cancellation
C. some exposures may require separate policies or endorsements
D. excluded losses are still paid, but at actual cash value

**912. Farm insurance is designed to address exposures related to:**

A. federally subsidized crop yield guarantees
B. personal auto and recreational vehicle risks
C. commercial trucking and cargo hauling risks
D. farm property and farm liability risks

**913. A farm policy may combine elements similar to homeowners and commercial coverage because a farm often includes:**

A. both residence and business/agricultural exposures
B. only ocean cargo exposures
C. only personal umbrella coverage
D. only employee retirement benefits

**914. Farm personal property coverage may be used for items such as:**

A. a tenant's health insurance deductible
B. farm machinery, equipment, and supplies
C. the insured's life insurance cash value
D. a corporate surety bond only

**915. Why is livestock coverage usually reviewed carefully in a farm policy?**

A. livestock is valued at replacement cost with no per-head limit under the standard form
B. livestock losses are covered while the animals are inside an insured building, not in pasture
C. coverage may depend on causes of loss, limits, schedules, and exclusions
D. livestock is covered for death from natural causes and old age under basic perils

**916. A farm liability coverage part generally addresses:**

A. damage to the farmer's own machinery and equipment caused by a covered peril
B. injuries to farm employees that are subject to the state workers compensation law
C. losses of livestock and crops caused by disease, drought, or flooding
D. covered bodily injury or property damage claims arising from farm operations

**917. Which item is most clearly a farm property exposure?**

A. a tractor used in farming operations
B. a farm owner's personal liability lawsuit
C. a hired hand injured while baling hay
D. livestock injuring a visitor on the farm

**918. Why might a farm need separate commercial auto or mobile equipment review?**

A. farm policies exclude tractors, so each one needs a separate auto policy
B. vehicles and equipment may not all fit neatly under farm property coverage
C. federal crop insurance already covers farm vehicles, so duplicate coverage must be avoided
D. the farm liability section already covers vehicles registered for public road use

**919. A farm also hosts paid public events. What should the producer review?**

A. whether guest injuries can be paid from the farm property coverage limit
B. whether workers compensation will respond to injuries suffered by paying guests
C. whether agritourism or business liability exposures need special coverage
D. whether crop insurance should be increased to reflect the added event income

**920. Equipment breakdown coverage is designed to cover sudden and accidental breakdown of covered equipment such as:**

A. boilers, electrical systems, or mechanical equipment
B. buildings, outdoor fences, and detached structures
C. inventory, raw materials, and finished goods in storage
D. vehicles, trailers, and mobile equipment driven on public roads

**921. Which loss is equipment breakdown coverage most directly intended to address?**

A. a boiler that fails from years of ordinary wear and tear
B. a lightning strike that ignites a fire inside the building wiring system
C. a machine destroyed by flooding of the basement machine room
D. a covered electrical system failure damaging business equipment

**922. Spoilage coverage may be relevant with equipment breakdown when:**

A. a refrigerator is stolen along with the goods stored inside it
B. refrigerated goods spoil after covered refrigeration equipment fails
C. food is contaminated by an employee's deliberate tampering
D. inventory in cold storage is damaged by a fire that spreads through the warehouse

**923. Why may equipment breakdown coverage be needed even when a property policy covers fire?**

A. property forms cover the breakdown itself but exclude the fire that follows it
B. property forms exclude fire damage to equipment, so a second policy is needed
C. standard property forms may exclude or limit mechanical breakdown losses
D. equipment breakdown is required by law once a business owns a boiler

**924. Expediting expense coverage under equipment breakdown may help pay for:**

A. lost profits during the period the equipment is out of service
B. scheduled preventive maintenance performed to avoid a future breakdown
C. the cost of replacing spoiled inventory that resulted from the breakdown
D. extra costs to speed up repairs or replacement after a covered breakdown

**925. A boiler explosion exposure is commonly associated with which coverage concept?**

A. equipment breakdown
B. personal umbrella only
C. life nonforfeiture options
D. health coinsurance

**926. Which business may especially need equipment breakdown coverage?**

A. a person buying only term life insurance
B. a grocery store relying on refrigeration equipment
C. a tenant with no business equipment exposure
D. a driver insuring one personal sedan

**927. A covered power surge damages production machinery and causes downtime. Which combination may be relevant?**

A. commercial general liability and products-completed operations
B. building coverage and workers compensation disability benefits
C. equipment breakdown and business income/extra expense coverage
D. commercial auto physical damage and hired/non-owned auto liability

**928. Professional liability insurance is mainly designed for claims involving:**

A. bodily injury or property damage occurring on the premises
B. employee injuries arising out of employment
C. advertising injury such as slander or libel
D. professional errors, omissions, or negligent advice

**929. Why might a consultant need professional liability coverage even if they have general liability coverage?**

A. general liability may not cover financial loss from professional advice errors
B. general liability covers advice errors, but its per-occurrence limit is too low
C. professional liability is required by statute for anyone who charges consulting fees
D. general liability covers advice errors, but it excludes claims by corporate clients

**930. Errors and omissions coverage is another common name for:**

A. homeowners property coverage
B. professional liability coverage
C. personal auto collision coverage
D. workers compensation coverage

**931. A client alleges that an insurance agent failed to procure requested coverage. Which coverage may respond for the agent?**

A. personal auto comprehensive coverage
B. equipment breakdown only
C. errors and omissions liability
D. commercial property building coverage

**932. Many professional liability policies are written on which basis?**

A. cash value accumulation basis
B. personal auto split-limit basis only
C. guaranteed lifetime benefit basis
D. claims-made basis

**933. Why is a retroactive date important in a claims-made professional liability policy?**

A. claims from acts before that date may not be covered
B. claims must be reported within one year of that date
C. acts after that date are covered under the prior policy
D. it fixes the date on which the extended reporting period begins

**934. Tail coverage, or an extended reporting period, is used to:**

A. extend the policy period so new acts stay covered after expiration
B. allow certain claims to be reported after a claims-made policy ends
C. move the retroactive date backward to pick up earlier acts
D. convert a claims-made policy into an occurrence policy at renewal

**935. Which occupation commonly has a professional liability exposure?**

A. a retail clerk stocking shelves for a store
B. a landlord renting an apartment to a tenant
C. an accountant giving professional tax advice
D. a delivery driver operating a company truck

**936. After a property loss, the insured is generally expected to:**

A. ignore policy conditions
B. increase the policy limit after the loss
C. repair everything without telling the insurer
D. give prompt notice to the insurer

**937. A proof of loss is best described as:**

A. a formal statement of the details and amount of a claimed loss
B. the adjuster's written estimate of the cost to repair the damage
C. the insurer's written acknowledgment that a claim has been received
D. a release the insured signs when accepting the final claim payment

**938. The duty to protect property from further damage after a covered loss is often called:**

A. rebating
B. mitigation of damages
C. adverse selection
D. waiver of subrogation

**939. An insurer pays the insured for damage caused by a negligent third party and then seeks recovery from that party. This is an example of:**

A. concealment
B. coinsurance
C. subrogation
D. vicarious liability

**940. Salvage in property insurance commonly refers to:**

A. the amount recovered from a negligent third party
B. property the insured abandons to the insurer for full payment
C. the deductible the insured absorbs before payment
D. damaged property that has remaining value after a loss

**941. Why is documentation important after a property loss?**

A. it helps support the amount, cause, and details of the claim
B. it waives the insured's duty to protect property from further damage
C. it is required before the insurer may inspect the damaged property
D. it obligates the insurer to accept the insured's valuation of the loss

**942. An adjuster's main role in the claims process is to:**

A. decide whether the policy will be renewed at expiration
B. investigate, evaluate, and help resolve claims
C. act as the insurer's attorney in coverage litigation
D. calculate premiums and rate classifications for the insurer

**943. A deductible is the amount that:**

A. the insurer subtracts from each premium as an underwriting fee
B. the insured pays above the policy limit when a loss exceeds it
C. the insured usually pays or absorbs before insurance payment applies
D. the insurer withholds from the settlement until the salvage is sold

**944. An endorsement is used to:**

A. bind coverage until the policy is issued
B. summarize the policy's key terms for the insured
C. record the insured's premium payment history
D. add to, remove, or change policy terms

**945. An inflation guard endorsement on a property policy does what?**

A. Freezes the premium for three years
B. Automatically increases the building coverage limit by a set percentage over time
C. Waives the deductible during periods of high inflation
D. Converts the policy from replacement cost to actual cash value

**946. An additional insured endorsement generally:**

A. names a second party to receive claim payments for damaged property
B. adds another party as an insured for specified coverage purposes
C. transfers the policy to a new owner with the insurer's consent
D. designates a party the insurer agrees not to pursue in subrogation

**947. A waiver of subrogation endorsement usually means the insurer:**

A. extends insured status to a specified party for claims arising from the insured's work
B. agrees to pay a specified party directly before the named insured receives any payment
C. agrees not to pursue recovery from a specified party after paying a covered loss
D. gives up its right to cancel the policy while the specified party holds an interest

**948. A loss payable clause is commonly used to protect the interest of:**

A. a contractor doing work for the insured under a written agreement
B. a tenant who occupies part of the insured building under a lease
C. an employee who is injured while using the insured's equipment
D. a lender or other party with a financial interest in covered property

**949. Why should endorsements be reviewed with the base policy?**

A. endorsement wording can change the meaning of coverage, limits, and exclusions
B. the base policy wording overrides any endorsement that conflicts with it
C. endorsements expire at the first renewal unless they are re-signed
D. endorsements bind the insurer but do not bind the insured who accepted them

**950. A named perils endorsement or form covers losses only when:**

A. the cause of loss is not specifically listed as excluded
B. the cause of loss is specifically listed as covered
C. the loss exceeds the deductible stated in the schedule
D. the cause of loss is both sudden and accidental in nature

**951. Which statement about endorsements is most accurate?**

A. They must be attached at policy inception and cannot be added during the term.
B. They broaden coverage but are not permitted to add exclusions.
C. They should be read because they can change the original policy wording.
D. They require a separate premium and a separate policy number.

**952. A contractor damages a customer's wall while performing work. Which coverage area is most likely involved?**

A. life insurance settlement options
B. workers compensation wage benefits
C. equipment breakdown spoilage
D. commercial general liability

**953. A windstorm damages the roof of an insured building. Which coverage area is most directly involved?**

A. commercial property coverage
B. professional liability coverage
C. employee dishonesty only
D. commercial auto liability

**954. A business employee is injured while performing job duties. Which coverage is most directly designed for that exposure?**

A. professional liability
B. workers compensation
C. equipment breakdown
D. commercial property coverage

**955. A store customer slips and is injured on the premises. Which coverage area is most likely involved?**

A. medical payments under the business auto policy
B. workers compensation medical benefits coverage
C. premises liability under general liability coverage
D. products-completed operations liability coverage under the CGL

**956. A computer consultant's faulty advice causes a client financial loss but no bodily injury or property damage. Which coverage should be reviewed?**

A. homeowners medical payments
B. workers compensation
C. commercial auto physical damage
D. professional liability

**957. A restaurant refrigerator breaks down and food spoils. Which coverage combination may be relevant?**

A. equipment breakdown with spoilage coverage
B. business income with an ordinance or law endorsement
C. commercial property with fire legal liability
D. products liability with a recall expense endorsement

**958. A business rents a van for a one-week project. Which commercial auto exposure should be reviewed?**

A. non-owned auto coverage for employee vehicles
B. hired auto liability and physical damage needs
C. garagekeepers legal liability for customer vehicles
D. uninsured motorist coverage on the owned fleet

**959. A policy excludes flood, but the insured suffers flood damage to a building. What is the likely coverage concern?**

A. the deductible disappears
B. the claim must be paid under auto liability
C. the loss may require separate flood coverage
D. the exclusion automatically becomes invalid

**960. A business has property at multiple locations. Why are location schedules important?**

A. they extend coverage to any newly acquired location for a full year
B. they eliminate the coinsurance requirement for scheduled locations
C. they allow the insured to move limits between locations after a loss
D. coverage and limits may apply differently by listed location

**961. Why might a contractor need both CGL and inland marine coverage?**

A. CGL addresses liability claims, while inland marine may cover tools or equipment in transit or at job sites
B. CGL covers tools and equipment at job sites, while inland marine addresses liability for injury to others
C. CGL covers work performed on the premises, while inland marine covers liability arising off the premises
D. CGL covers the contractor's own building and contents, while inland marine covers vehicles used on the job

**962. A claims-made liability policy is canceled without replacement. What should the insured consider?**

A. adding comprehensive auto coverage to a personal car
B. an extended reporting period if available
C. naming a life insurance beneficiary
D. changing the building deductible

**963. A blanket insurance limit is best described as a limit that may apply:**

A. to one specifically described item at a stated insurance amount
B. to all locations, but at no more than the value of any one
C. over more than one item or location, depending on policy wording
D. to property away from the premises for a stated period of days

**964. A property policy has a coinsurance clause. Why is the insured value important?**

A. the insurer may pay more than the face limit when values rise
B. the insured is required to pay a share of every loss regardless of limit
C. premium credits apply once the insured value exceeds the coinsurance amount
D. underinsurance may reduce claim payment after a partial loss

**965. Which situation best illustrates a moral hazard?**

A. an insured intentionally exaggerates a claim because insurance will pay
B. an insured leaves doors unlocked because the property is insured for full value
C. a worker stores flammable solvents in an unventilated wooden shed
D. a building in a high-crime area is left without an alarm system

**966. Why should coverage be reviewed when a business changes operations?**

A. only the logo needs to change
B. new activities can create exposures not contemplated by the current policy
C. state insurance law requires no updates
D. coverage automatically expands to every new activity without limit

**967. A fire destroys an insured home, and the investigation shows the named insured intentionally set the fire. The lender is named under a standard mortgage clause. How does this affect the lender?**

A. The lender is paid only if it can prove it had no knowledge of the arson before the policy was issued
B. The lender must sue the insured directly and has no rights under the policy
C. The lender may still collect its share of the loss even though the insured's own claim is denied
D. The lender loses all rights because the policy is void from inception

**968. Under a standard mortgage clause, which obligation does the mortgagee accept in exchange for its protected status?**

A. It must inspect the property at least once each year and certify to the insurer that no increase in hazard exists
B. It must keep the property insured for at least the outstanding loan balance plus interest, and forfeit its rights if the amount falls short
C. It must absorb the insured's deductible on every claim and waive its right to receive separate notice of cancellation from the insurer
D. It must pay the premium if the owner does not, and notify the insurer of a known increase in hazard or change in ownership

**969. How does a loss payable clause covering a financed piece of equipment generally differ from a standard mortgage clause on a building?**

A. The loss payee's right to payment usually rises and falls with the insured's own right to recover
B. The loss payee is paid first regardless of any defense the insurer could raise against the insured
C. The loss payee receives a separate policy from the insurer that covers its own financial interest alone
D. The loss payee must receive a full year of advance written notice before the insurer may cancel

**970. An insurer agrees the fire loss is covered but says the damaged inventory is worth far less than the insured claims. Which policy condition is designed for this exact situation?**

A. The concealment or fraud condition
B. The appraisal condition
C. The subrogation condition
D. The liberalization condition

**971. Appraisal has been demanded, each side has selected an appraiser, and the two appraisers cannot agree on the amount of the loss. What happens next under the typical appraisal condition?**

A. The claim is referred to the state insurance department, whose examiner issues a binding valuation ruling
B. The insurer's appraiser figure controls, since the insurer bears the appraisal cost and pays the claim
C. The appraisers submit their differences to an umpire, and agreement by any two of the three sets the amount
D. The insured must file suit within thirty days of the deadlock or forfeit the right to contest the amount

**972. A proof of loss under a typical property policy is best described as which of the following?**

A. A signed release the insured returns acknowledging that the claim payment received represents full and final settlement

B. A police or fire department report that the insured files with the insurer in place of a personal statement of the loss

C. The adjuster's written estimate of repair costs, which the insurer must give the insured within sixty days of the loss

D. A sworn statement of the loss that the insured signs and returns, usually within sixty days after the insurer requests it

**973. A building is insured under two policies from different insurers, each written on a pro rata basis. Policy One carries a limit of $300,000 and Policy Two carries a limit of $100,000. A covered loss of $40,000 occurs. How does the other insurance condition allocate the payment?**

A. Policy One pays $30,000 and Policy Two pays $10,000

B. Policy One pays the entire $40,000 because it has the larger limit

C. The insured selects one insurer to pay the full amount and that insurer collects nothing from the other

D. Each insurer pays $20,000 because both policies cover the same loss

**974. Which action by an insured is most likely to impair the insurer's subrogation rights and jeopardize the claim payment?**

A. Providing the insurer with the name and contact information of the responsible party

B. Signing a release after the loss that frees the responsible third party from all liability

C. Reporting the loss to the police as soon as it is discovered

D. Allowing the insurer to inspect the damaged property before repairs begin

**975. What does the abandonment condition found in property policies provide?**

A. The insurer must accept damaged property and pay the limit whenever repairs would exceed half the value

B. The insured must abandon all salvage rights to the insurer as a condition of any claim payment

C. The insured may not turn damaged property over to the insurer and demand payment of the full policy limit

D. The insurer may abandon the claim without explanation if the insured delays filing proof of loss

**976. Which statement best distinguishes cancellation from nonrenewal?**

A. Cancellation requires no advance notice to the insured, while nonrenewal requires written notice before the expiration date

B. Cancellation is used for commercial policies, while nonrenewal is the method used to end personal lines policies

C. Cancellation is a right available to the insured but not the insurer, while nonrenewal is a right available to the insurer but not the insured

D. Cancellation ends coverage during the policy term, while nonrenewal lets the current term run out and declines to issue a new one

**977. An insured sells her building and wants the buyer to take over her existing property policy. Under the assignment condition, what is required?**

A. The insurer's written consent, because the policy insures the person and not the building

B. Nothing beyond recording the deed, because the property policy transfers automatically with the title

C. Written notice to the mortgagee, because the lender controls who is insured under the policy

D. A proof of loss form filed by the buyer within sixty days, because ownership changes are treated as losses

**978. For an insurer to void coverage under the concealment or fraud condition, the withheld or false information must be which of the following?**

A. Contained in the written application rather than given orally

B. Material, meaning it would have affected the insurer's underwriting or rating decision

C. Related solely to the insured's prior claims history

D. Discovered by the insurer within the first thirty days of the policy period

**979. An insurer broadens its standard homeowners form to cover an additional situation at no extra charge while an insured's policy is already in force. Which condition gives that insured the benefit of the change?**

A. The appraisal condition

B. The other insurance condition

C. The liberalization condition

D. The no benefit to bailee condition

**980. An insured leaves an area rug at a cleaning business, and the rug is destroyed in a fire at that business. The insured's homeowners policy pays the claim. What does the no benefit to bailee condition accomplish?**

A. It requires the cleaning business to reimburse the insured's deductible

B. It obligates the insured's insurer to defend the cleaning business against other customers' claims

C. It voids the insured's coverage because the property was off premises

D. It prevents the cleaning business from using the insured's policy as a shield against its own liability

**981. One dining chair from a matched set of eight is destroyed by a covered peril, and no replacement chair is available. Under the pair or set condition, how is the loss most likely settled?**

A. The insurer pays the difference between the value of the set before the loss and its value after the loss

B. The insurer pays nothing because a single chair is not a separate insured item

C. The insurer pays the full limit for personal property because the set can no longer be matched

D. The insurer replaces all eight chairs with a new matching set of equal quality

**982. When must insurable interest exist for a property insurance claim to be payable?**

A. Only at the time the first premium is paid

B. At the time of the loss

C. Continuously from application through the end of the policy period

D. Only at the time the application is signed

**983. A dwelling policy is written on the basic form without any optional perils added. Which group of perils does it cover?**

A. Theft, vandalism, and accidental discharge of water

B. Falling objects, weight of ice and snow, and freezing of plumbing

C. Fire, lightning, and internal explosion

D. All risks of direct physical loss except those specifically excluded

**984. Which statement correctly compares loss settlement for the dwelling under the basic dwelling form and the broad dwelling form?**

A. Both the basic and broad forms settle the dwelling at actual cash value, and replacement cost settlement is available under the special form alone

B. The basic form settles at replacement cost, while the broad form settles at actual cash value unless the insured carries eighty percent of value

C. Both forms settle the dwelling at replacement cost without deduction for depreciation, regardless of the amount of insurance carried relative to value

D. The basic form settles the dwelling on an actual cash value basis, while the broad form provides replacement cost when the coinsurance requirement is met

**985. How does the special dwelling form treat perils for the dwelling compared with personal property?**

A. Open perils on the dwelling and other structures, with broad named perils on personal property

B. Open perils on personal property, with broad named perils on the dwelling and other structures

C. Open perils on the dwelling, other structures, and personal property alike, subject to the exclusions

D. Broad named perils on the dwelling and other structures, with basic named perils on personal property

**986. A detached storage shed and a fence on the described location are damaged by a covered peril under a dwelling policy. Which coverage responds?**

A. Coverage C, because the structures hold the insured's belongings

B. Coverage B, other structures

C. Coverage D, because the structures affect the rental value of the premises

D. Coverage A, because all structures on the lot are part of the dwelling

**987. An owner rents out a house insured under a dwelling policy. A covered fire makes the house unfit to live in, and the tenant stops paying rent during repairs. Which coverage is designed for the owner's lost income?**

A. Coverage E, additional living expense
B. Coverage C, personal property
C. Coverage D, fair rental value
D. Coverage B, other structures

**988. Which statement about additional living expense coverage under dwelling forms is correct?**

A. It is included in all three dwelling forms at ten percent of the Coverage A limit as an additional amount of insurance
B. It pays the insured's mortgage and property tax payments while the dwelling is uninhabitable after a covered loss
C. It is designed for dwellings rented to others, while an owner occupant relies on fair rental value coverage instead
D. It is not automatically included in the basic dwelling form and generally must be added by endorsement

**989. Which is a key difference between a dwelling policy and a homeowners policy?**

A. A dwelling policy does not automatically include personal liability or theft coverage, while a homeowners policy does
B. A dwelling policy automatically includes theft coverage for contents, while a homeowners policy requires a theft endorsement
C. A dwelling policy includes Section II personal liability coverage automatically, while a homeowners policy requires a liability supplement
D. A dwelling policy settles the dwelling at replacement cost under every form, while a homeowners policy pays actual cash value on the dwelling

**990. Which risk is most clearly eligible for a dwelling policy but not for a standard owner-occupied homeowners policy?**

A. A single-family home occupied year round by the owner and her family
B. A four-family rental dwelling owned by an investor who lives elsewhere
C. A condominium unit that the insured owns and occupies as a primary residence
D. An apartment occupied by a tenant who owns the contents but not the building

**991. An insured with a dwelling policy is concerned that inflation is eroding the adequacy of the Coverage A limit between renewals. Which endorsement addresses this concern?**

A. A broad theft coverage endorsement
B. A dwelling under construction endorsement
C. An automatic increase in insurance endorsement
D. A personal liability supplement

**992. A dwelling insured under a dwelling policy has been unoccupied and empty of contents for more than sixty consecutive days when vandals break in and damage the interior. What is the likely result?**

A. The claim is paid but the limit is reduced by half
B. The claim is paid only if the insured notified the insurer before the vandalism occurred
C. The claim is paid in full because vandalism is a covered peril
D. The vandalism loss is excluded because of the vacancy provision

**993. A building has a replacement cost of $200,000 and is insured for $120,000 under a policy with an 80 percent coinsurance clause. A covered loss of $40,000 occurs, and the deductible is ignored. How much does the insurer pay?**

A. $40,000
B. $24,000
C. $30,000
D. $32,000

**994. An insured carries less than the required coinsurance percentage and suffers a loss that exceeds the policy limit. What is the maximum the insurer will pay?**

A. The policy limit, since the coinsurance calculation can never produce a payment above the stated limit
B. The full amount of the loss less the deductible, since a loss above the limit shows the insured was adequately

covered

C. The amount the insured should have carried under the coinsurance clause, less the deductible, as the insurer's true exposure

D. The policy limit multiplied by the coinsurance percentage, since the insurer shares the loss in that proportion

**995. An older building has ornate hand carved plaster ceilings that would be enormously expensive to duplicate. The policy settles losses on a functional replacement cost basis. What does the insurer pay?**

A. The cost to repair or rebuild with materials of like kind and quality, duplicating the hand carved plaster at today's prices

B. The cost to repair or rebuild using modern materials that serve the same function, even though they are not identical

C. The actual cash value of the ceilings, meaning the cost of identical materials less depreciation for age and condition

D. The market value of the building immediately before the loss, less the value of the land on which the building sits

**996. An insured submits a signed statement of values and the insurer attaches an agreed value provision. What effect does this have?**

A. It converts the settlement basis from replacement cost to actual cash value for the policy term

B. It guarantees payment of the full policy limit for any partial loss to the covered property

C. It waives the deductible on all covered losses to the property listed on the statement

D. It suspends the coinsurance clause for the covered property during the policy term

**997. A specialized piece of mobile equipment is insured on a stated amount basis. If it is destroyed, how is the loss generally settled?**

A. At the lesser of the stated amount or the actual value of the item at the time of loss

B. At the greater of the stated amount or the actual cash value of the item at the time of loss

C. At the stated amount in full, because listing that figure makes it a guaranteed valued amount

D. At the replacement cost of the equipment new, with the stated amount serving as the deductible

**998. An insured is comparing a split limit auto liability policy with a combined single limit policy carrying the same total dollars. What is the practical advantage of the combined single limit?**

A. One limit applies to each injured person, so several claimants in one accident can each collect the full amount without exhausting the limit

B. One limit applies to bodily injury and property damage combined per accident, so it is not constrained by separate per person or per accident caps

C. One limit applies per policy period rather than per accident, so multiple accidents during the year draw on a single larger pool of coverage that resets at renewal

D. It automatically extends the same single limit to uninsured motorist and medical payments coverage without a separate premium charge

**999. A coastal property policy applies a two percent windstorm deductible to a building insured for $300,000, while all other losses carry a $1,000 flat deductible. A covered hurricane loss of $50,000 occurs. What amount is deducted?**

A. $6,000

B. $1,000

C. $1,900

D. $5,000

**1000. A homeowners policy with $100,000 of personal property coverage limits recovery for theft of jewelry to $1,500. This inner limit is best described as which of the following?**

A. An aggregate limit for the policy period

B. A coinsurance penalty

C. A sublimit within the personal property coverage

D. A separate deductible applying only to jewelry

**1001. An insurer supplies a producer with company signs, applications, and letterhead. A customer reasonably believes the producer can bind a type of coverage the company has privately forbidden. Which type of authority is involved?**

A. Express authority

B. Fiduciary authority

C. Implied authority

D. Apparent authority

**1002. An insured pays a $900 annual premium and later collects $60,000 for a covered fire. Which characteristic of insurance contracts does this illustrate?**

A. Unilateral, because the insured's promise to pay premium is the sole enforceable obligation created by the contract

B. Aleatory, because the values exchanged by the parties may be very unequal and depend on an uncertain event

C. Conditional, because the insurer could not enforce payment of the premium until the covered fire actually occurred

D. Adhesion, because the unequal exchange shows the insured had no power to negotiate the amount of the premium

**1003. A court finds that a policy exclusion is genuinely ambiguous and could reasonably be read two different ways. How is the ambiguity most likely resolved, and why?**

A. In favor of the insurer, because the insurer accepted the risk and is entitled to the benefit of the doubt

B. By referring the wording to the state insurance department, whose reading of an approved form is binding

C. In favor of the insured, because the contract is one of adhesion drafted solely by the insurer

D. By voiding the exclusion and the entire policy, since an ambiguous term makes the contract unenforceable

**1004. Which statement best contrasts a warranty with a representation in an insurance contract?**

A. A representation is a statement guaranteed to be true and becomes part of the contract, while a warranty need only be substantially true when made

B. Both a warranty and a representation must be literally true in every detail, and any inaccuracy in either voids the policy from inception

C. A warranty applies to statements made by the insurer in the policy, while a representation applies to statements made by the applicant

D. A warranty is a statement guaranteed to be true and becomes part of the contract, while a representation need only be substantially true when made

**1005. An insurer learns of a clear policy violation but accepts premium and adjusts several later claims without objection. The insurer then tries to deny a new claim on that same violation. Which doctrine most likely prevents the denial?**

A. Estoppel, following the insurer's voluntary waiver of the known right

B. Subrogation, because the insurer stepped into the insured's position

C. Utmost good faith, which binds the insured to disclose the violation

D. Indemnity, limiting the insurer to restoring the insured's position

**1006. Which of the following is the clearest example of a physical hazard?**

A. An insured who has previously submitted an inflated claim

B. Worn wiring and an overloaded electrical panel in an older building

C. An insured who leaves doors unlocked because insurance will pay

D. An insured who exaggerates the value of a stolen laptop

**1007. A manufacturer decides to stop producing a product line entirely because its liability exposure cannot be managed at an acceptable cost. Which risk management technique is this?**

A. Reduction

B. Retention

C. Avoidance

D. Transfer

**1008. An insurer has an arrangement under which the reinsurer automatically accepts every risk of a defined class the insurer writes, without reviewing each one. What is this called?**

A. Facultative reinsurance

B. A residual market pool

C. Retrocession to the original insured

D. Treaty reinsurance

**1009. What is the primary purpose of a FAIR Plan?**

A. To make basic property insurance available to owners of eligible properties who cannot obtain it in the voluntary market

B. To pay the covered claims of policyholders whose admitted property insurer has been declared insolvent by a court

C. To provide flood insurance to property owners in communities that have adopted approved floodplain management rules

D. To distribute high risk auto applicants among licensed insurers in proportion to their share of the state's premium

**1010. A homeowner directly on a hurricane exposed shoreline cannot find a private insurer willing to write windstorm coverage. Which residual market mechanism is most likely designed for this situation?**

A. A state guaranty association

B. A beach and windstorm plan

C. An automobile assigned risk plan

D. A workers compensation rating bureau

**1011. How does an automobile assigned risk plan typically operate?**

A. Applicants who cannot obtain coverage voluntarily are insured directly by the state, which issues the policy and pays claims from an assessment on all insurers

B. Applicants who cannot obtain coverage voluntarily are referred to non-admitted surplus lines carriers after a diligent search of the admitted market

C. Applicants who cannot obtain coverage voluntarily are distributed among participating insurers in proportion to their share of the state's business

D. Applicants who cannot obtain coverage voluntarily are insured by the FAIR Plan, which writes auto liability alongside basic property coverage

**1012. Before placing a risk with a surplus lines insurer, a producer is generally required to do which of the following?**

A. Convert the applicant's existing policy to an assigned risk plan

B. Obtain approval of the policy form and rates from the insurance department

C. Add the risk to the state FAIR Plan first

D. Document a diligent search showing that admitted insurers declined the risk

**1013. Which statement correctly describes an admitted insurer compared with a non-admitted insurer?**

A. An admitted insurer holds a certificate of authority in the state and is generally subject to form and rate filing requirements, while a non-admitted insurer is not licensed there

B. An admitted insurer is one domiciled in the state, while a non-admitted insurer is a foreign or alien insurer that has been licensed to do business there under a different classification

C. An admitted insurer is exempt from state form and rate filing requirements, while a non-admitted insurer must file its forms and rates before writing surplus lines business

D. An admitted insurer is regulated by the state insurance department, while a non-admitted insurer is licensed and regulated by the federal government under the surplus lines law

**1014. How does a state guaranty association differ in purpose from a residual market plan?**

A. The guaranty association provides coverage to applicants the voluntary market rejects, while residual market plans pay covered claims of insolvent admitted insurers

B. The guaranty association pays covered claims of insolvent admitted insurers, while residual market plans provide coverage to applicants the voluntary market rejects

C. The guaranty association pays covered claims of insolvent surplus lines insurers, while residual market plans protect policyholders of insolvent admitted insurers

D. The guaranty association reimburses member insurers for catastrophic losses above a retention, while residual

market plans provide coverage of last resort for property alone

**1015. A homeowner with no mortgage transaction pending buys a federal flood policy as a storm approaches. When does coverage normally become effective?**

A. At 12:01 a.m. on the day after the application is signed

B. Immediately upon payment of the full annual premium to the agent

C. Thirty days after the application and premium are submitted

D. Fourteen days after the application and premium are submitted

**1016. Floodwater fills a finished basement used as a family room. Which statement best describes federal flood coverage for that area?**

A. Coverage in below grade areas is the same as for above grade living space, so finished walls, flooring, furniture, and contents in the family room are paid up to the policy limits

B. Coverage in below grade areas is excluded entirely, so neither the foundation walls nor the furnace and electrical panel in the basement are covered under the program

C. Coverage in below grade areas reaches finished improvements such as drywall and carpeting, but excludes structural elements and building equipment like the furnace and water heater

D. Coverage in below grade areas is sharply limited, generally reaching structural elements and essential building equipment rather than finished improvements and most personal property

**1017. A tenant wants federal flood coverage for furniture and belongings in a rented house. What must the tenant do?**

A. Purchase contents coverage, which is bought separately from building coverage and carries its own limit and deductible

B. Purchase building coverage in the tenant's name, since contents coverage is included with the building limit

C. Ask the landlord to add a contents endorsement to the building policy naming the tenant as an additional insured

D. Rely on the landlord's building coverage, which extends to a tenant's belongings up to 10% of the building limit

**1018. Under the Write Your Own arrangement in the federal flood program, what role does the private insurer play?**

A. It issues and services flood policies in its own name and retains the underwriting profit or loss, while the federal program reinsures losses above a retention

B. It issues and services flood policies in its own name and adjusts claims, while the federal program bears the underwriting risk

C. It acts as a reinsurer of the federal program, accepting a share of flood losses in exchange for a share of the premium, but does not issue policies

D. It sells excess flood coverage above the federal program's limits in its own name, while the federal program writes the primary layer directly

**1019. Why do standard homeowners policies exclude flood?**

A. Because federal law reserves flood insurance to the national program, so private insurers are barred from covering flood on any residential or commercial property

B. Because flood losses are frequent but small, so the administrative cost of adjusting them would exceed the premium the peril could support

C. Because flood losses are catastrophic and highly concentrated, and mainly those in flood prone areas would buy the coverage, creating adverse selection

D. Because flood damage results from a gradual process rather than a sudden event, so it fails the requirement that an insurable loss be accidental

**1020. After a severe flood, a community declares an insured building substantially damaged and requires it to be elevated to current floodplain standards before rebuilding. Which federal flood coverage helps with that requirement?**

A. Loss avoidance coverage for sandbagging

B. Business income coverage

C. Additional living expense coverage

D. Increased Cost of Compliance coverage

**1021. Under the federal terrorism risk insurance law, what is an insurer writing eligible commercial property and casualty lines required to do?**

A. Make terrorism coverage available on terms not differing materially from those applying to other covered losses

B. Include terrorism coverage in every eligible policy at no additional premium, since the federal government funds the losses

C. Exclude certified acts of terrorism from all eligible policies and refer the exposure to the federal program directly

D. Offer terrorism coverage at a separately filed rate approved by the Treasury Department before any policy is issued

**1022. A retailer suffers a ransomware attack. It incurs forensic investigation costs, data restoration expenses, and lost income during the shutdown, and it is later sued by customers whose data was exposed. How do cyber coverages respond?**

A. Cyber liability coverage addresses the retailer's own investigation, restoration, and income loss, while first party cyber coverage responds to the customers' claims

B. First party cyber coverage addresses the forensic investigation and data restoration, while the lost income and the customers' claims both fall under cyber liability

C. First party cyber coverage addresses the retailer's own investigation, restoration, and income loss, while cyber liability responds to the customers' claims

D. First party cyber coverage responds to the customers' claims and the lost income, while the forensic and restoration costs are paid under the commercial property form

**1023. A driver has logged into a rideshare app and is waiting for a ride request when she causes an accident. Why is this period a recognized coverage gap?**

A. Because the personal auto policy covers the driver in full during this period, while the network company's commercial policy does not attach until a ride request is accepted

B. Because the personal auto policy typically excludes use of the vehicle as a public or livery conveyance, while the network company's contingent coverage in this period is often narrow

C. Because the network company's commercial policy provides full primary coverage from the moment the app is on, while the personal auto policy is excess and often refuses to contribute

D. Because the personal auto policy excludes any vehicle used for business purposes of any kind, and the network company provides no coverage until a passenger is actually in the vehicle

**1024. A fire destroys forty percent of an older building, and the local code requires the remaining undamaged portion to be torn down and the whole structure rebuilt to current standards. Which combination of costs does ordinance or law coverage typically address?**

A. The increased cost of rebuilding to current code and the demolition of the undamaged portion, but not the loss of value in that undamaged portion

B. The loss to the undamaged portion and the demolition cost, but not the increased cost of construction, which falls under the standard building coverage

C. The increased cost of construction and the loss of value in the undamaged portion, with demolition and debris removal covered by the standard debris removal provision

D. The loss to the undamaged portion, the cost of demolition and debris removal for that portion, and the increased cost of construction

**1025. Why does a business with a standard commercial property policy still need equipment breakdown coverage?**

A. Because standard property forms generally exclude loss caused by mechanical breakdown, electrical arcing, and steam boiler explosion, which the equipment breakdown form covers

B. Because standard property forms cover mechanical breakdown but exclude the resulting fire and explosion damage, which the equipment breakdown form picks up

C. Because standard property forms exclude damage to machinery from any cause, so all equipment must be scheduled on an equipment breakdown form to be insured

D. Because standard property forms cover the building and contents but exclude all business income losses, which the equipment breakdown form provides for every covered peril

**1026. In addition to offering terrorism coverage, what disclosure duty does the federal terrorism risk insurance law place on insurers?**

A. They must disclose the identity of their reinsurers to each policyholder

B. They must clearly disclose the premium charged for terrorism coverage and the existence of federal participation in paying losses

C. They must disclose the loss ratio of the policyholder's classification

D. They must disclose the insurer's total surplus at the time of issuance

**1027. After days of heavy rain, a river near an insured's home overflows and water flows across the yard into the finished basement, ruining the flooring. How will the insured's standard homeowners policy respond?**

A. The loss is excluded because flood and surface water are not covered perils; separate flood insurance is needed

B. The loss is covered because water damage of any kind is a named peril

C. The loss is covered but only up to 10 percent of the dwelling limit

D. The loss is excluded only if the home sits in a designated flood zone

**1028. Weeks of rain saturate the hillside behind an insured's home, and part of the slope slides down and crushes an exterior wall. Which statement best describes coverage under a standard homeowners policy?**

A. The loss is covered because the landslide was sudden and accidental

B. The loss is covered under the falling objects peril

C. The loss is excluded as earth movement, which requires a separate policy or endorsement to insure

D. The loss is covered if the insured proves the slide was caused by weather

**1029. A fire heavily damages a 70-year-old insured home. When the owner applies for a rebuilding permit, the city requires a modern fire sprinkler system and upgraded wiring that the original house never had. Who pays the extra cost of these code upgrades under a standard homeowners policy?**

A. The insurer pays in full, because the upgrades are part of repairing the covered fire damage

B. Beyond any small built-in allowance, the insured pays, unless an ordinance or law endorsement was purchased

C. The city must subsidize the upgrades it requires

D. The insurer pays, but only if the home is insured for replacement cost

**1030. A windstorm shatters several windows in an insured home. The insured, away on a long trip, makes no effort to board up the openings, and over the next three weeks rain pours in and ruins the hardwood floors. How is the insurer likely to treat the floor damage?**

A. It may be denied, because the insured is required to protect the property from further damage after a loss

B. It must be paid, because the windstorm was the original covered cause

C. It is paid at actual cash value as a penalty for the delay

D. It is covered as long as the insured reports both losses within one year

**1031. An insured earns income caring for six children in her home each weekday. One child is injured, and the parents sue. Why might the insured's homeowners liability coverage fail to respond?**

A. Homeowners policies never cover injuries to minors

B. Childcare injuries are covered only under medical payments coverage

C. The claim exceeds the standard childcare sublimit of half the liability limit

D. Homeowners policies exclude or sharply limit liability arising from business activities, and paid daycare is a business

**1032. An insured files a homeowners claim when a ceiling develops water stains from a roof that has been slowly leaking for years because worn shingles were never replaced. What is the most likely outcome?**

A. The claim is paid, because interior water damage is always covered

B. The claim is paid if the insured replaces the roof within 90 days

C. The claim is denied, because damage from gradual deterioration and lack of maintenance is not covered

D. The claim is paid at replacement cost minus a maintenance surcharge

**1033. Rainwater drips through the 25-year-old roof of an insured warehouse and stains stored inventory. The adjuster finds the roof membrane simply deteriorated over decades with no storm damage. Why is the commercial property claim for the roof itself likely denied?**

A. Commercial property forms never cover roofs

B. Wear and tear and gradual deterioration are excluded because insurance covers fortuitous losses, not inevitable aging

C. Inventory losses must be insured under an inland marine policy

D. The insured failed to carry a roof maintenance warranty

**1034. The compressor motor in a grocery store's main refrigeration unit burns out from an internal electrical fault, and repairs cost $22,000. The store's commercial property policy denies the claim. Which coverage was the store missing?**

A. Equipment breakdown coverage, which insures mechanical and electrical breakdown that property forms exclude

B. Business income coverage, which pays all equipment repair bills

C. Inland marine coverage for movable machinery

D. Ordinance or law coverage for outdated equipment

**1035. A storm damages an electrical substation several miles from an insured restaurant. The restaurant loses power for two days, its food spoils, and it must close. There is no damage at the restaurant itself. Why does the restaurant's unendorsed property and business income coverage not respond?**

A. Restaurants are ineligible for business income coverage

B. Spoilage is never an insurable loss

C. Business income has a one-week waiting period for all closures

D. The utility failure originated away from the insured premises, an exposure that requires a utility services endorsement

**1036. A retailer discovers its bookkeeper diverted $40,000 of company funds into a personal account over two years. The retailer files a claim under its commercial property policy. What is the likely result?**

A. Covered, because money is business personal property

B. Denied, because dishonest acts of employees are excluded; the exposure is insured under commercial crime or fidelity coverage

C. Covered, but only for the most recent policy year

D. Denied, because the loss was not reported to police within 60 days

**1037. A business insures its building on a special (open perils) causes-of-loss basis. Which loss listed below would still be excluded despite the broad coverage?**

A. Damage from a military attack during an armed conflict

B. A kitchen fire that spreads to the roof

C. A burglar breaking through a wall to steal equipment

D. A delivery truck accidentally backing into the loading dock

**1038. During an argument, a shop owner deliberately shoves a customer, who falls and breaks a wrist. The customer sues, and the owner tenders the claim to the shop's CGL insurer. Why will the insurer likely deny coverage?**

A. Customers must claim under their own health insurance first

B. Assault claims are covered only under umbrella policies

C. The CGL excludes bodily injury expected or intended from the standpoint of the insured

D. The CGL covers property damage only, not bodily injury

**1039. A tavern continues serving a visibly intoxicated patron who later causes a serious car crash. The victim sues the tavern. How does the tavern's CGL policy treat this claim, and why?**

A. Covered, because the injury occurred away from the premises

B. Excluded, because the liquor liability exclusion applies to insureds in the business of selling or serving alcohol; a separate liquor liability policy is needed

C. Covered, because all CGL policies automatically include dram shop coverage

D. Excluded, because auto accidents can never create liability for a bar

**1040. A display case shatters in a store, cutting both a customer and a stock clerk who was restocking it. Under the store's CGL policy, whose injury can be paid under Coverage C medical payments?**

A. The clerk's only, because employees get priority

B. Both injuries, split equally

C. Neither, because glass injuries are excluded

D. The customer's only; the employee's injury is excluded from the CGL and belongs to workers compensation

**1041. An employee of a flower shop strikes a pedestrian while driving the shop's delivery van on a route. The pedestrian sues the shop. Why does the shop's CGL policy not defend this suit?**

A. The CGL excludes liability arising from the ownership or use of autos; a commercial auto policy is required

B. The employee, not the shop, is the only proper defendant

C. Pedestrian injuries fall under the products-completed operations hazard

D. The CGL covers vehicle claims only when the vehicle is parked

**1042. An architect's structural calculations prove wrong, and the building owner sues for the cost of reinforcing the finished structure. The architect's CGL insurer denies the claim. What coverage should the architect have carried for this exposure?**

A. A commercial umbrella over the CGL

B. Professional liability (errors and omissions) coverage, because the CGL excludes claims arising from rendering professional services

C. Builders risk insurance

D. Contractual liability coverage

**1043. A year after a contractor finishes a backyard deck, a defective support post fails. The collapse splinters the deck itself and crushes the homeowner's expensive grill sitting on it. How does the contractor's CGL policy respond to the homeowner's claim?**

A. It pays for both the deck and the grill

B. It pays nothing, because the work was already completed

C. It pays for the grill, but damage to the contractor's own completed work - the deck - is excluded

D. It pays for the deck only, because the grill is personal property

**1044. Hail destroys the roof of an insured building. Replacing the roof new would cost $18,000, and the adjuster determines the 15-year-old roof had depreciated by one-third of its value. If the policy settles at actual cash value and the deductible is ignored, how much does the insured receive?**

A. $6,000

B. $12,000

C. $18,000

D. $15,000

**1045. A kitchen fire damages an insured home covered on a replacement cost basis. The full cost to repair is $14,000, but the insurer's first check is only $9,000, the actual cash value. What must the insured typically do to collect the remaining $5,000?**

A. Nothing; the insurer must mail the balance within 30 days automatically

B. File suit for bad faith

C. Accept the $9,000 as final settlement

D. Actually complete the repairs or replacement and submit documentation, after which the insurer pays the withheld recoverable depreciation

**1046. A homeowner asks an agent to insure her house for its $400,000 market value. The agent instead recommends a dwelling limit near the $280,000 cost to rebuild the house. Why is the agent's number the better basis for the dwelling limit?**

A. The lower limit guarantees a lower deductible

B. Insurers are prohibited from writing limits above $300,000

C. Market value can only be used for condominium policies

D. Market value includes the land, which is not destroyed by insured perils; insurance should reflect the cost to rebuild the structure

**1047. A commercial building worth $500,000 is insured for $400,000 under a policy with an 80 percent coinsurance clause. A covered fire causes $60,000 in damage. Ignoring the deductible, how much does the insurer pay?**

A. $48,000

B. $40,000

C. $60,000, because the insured carried the full amount required by the coinsurance clause

D. $30,000

**1048. Several years after buying a homeowners policy, an insured has never updated the dwelling limit despite steep increases in construction costs, and the limit has slipped well below 80 percent of the home's full replacement cost. What consequence should the insured expect at claim time?**

A. The policy is automatically void

B. The insurer may reduce the amount it pays on a partial loss because the home is underinsured

C. Claims are unaffected as long as premiums were paid

D. Only total losses are penalized

**1049. A contractor carries a CGL policy with a $1 million each-occurrence limit and a $2 million general aggregate limit. In one policy period it suffers three separate covered losses: $900,000, $800,000, and $600,000. How much does the policy pay for the third loss?**

A. $300,000, because the first two claims used $1.7 million of the $2 million aggregate

B. $600,000, because it is under the occurrence limit

C. $1,000,000, the full occurrence limit

D. Nothing, because only two occurrences are covered per period

**1050. A driver with 100/300/50 split liability limits causes an accident injuring two people. One victim's bodily injury damages are $140,000 and the other's are $80,000. How much bodily injury liability does the policy pay in total?**

A. $220,000, the full amount of both claims

B. $300,000, the per-accident limit

C. $180,000: the first victim is capped at the $100,000 per-person limit and the second is paid $80,000 in full

D. $200,000, split equally between the victims

**1051. A business is sued and its CGL insurer spends $60,000 defending the case before a court awards the claimant damages equal to the policy's full $500,000 occurrence limit. How much does the insurer pay altogether?**

A. $500,000, because defense costs used up part of the limit

B. $560,000, because defense costs are supplementary payments made in addition to the policy limits

C. $440,000, the limit minus defense costs

D. $530,000, splitting the defense cost with the insured

**1052. A business owner is sued for slander, a claim his primary liability policies do not cover. His commercial umbrella policy, however, responds to the claim. What umbrella feature does this illustrate?**

A. Slander is uninsurable under any policy

B. Umbrellas always duplicate the underlying policy exactly

C. Umbrellas pay only after every other policy in the market is exhausted

D. An umbrella can cover certain claims the underlying policies do not cover at all, in addition to paying amounts above underlying limits

**1053. By June, a distributor's product liability claims have completely exhausted the general aggregate limit of its liability policy, which runs through December 31. In September a new covered claim arrives. What is the policy's position?**

A. The claim is paid from the next year's limits in advance

B. The occurrence limit still applies even though the aggregate is gone

C. The insurer must reinstate the aggregate on request at no charge

D. Nothing is payable for the September claim; a fresh aggregate limit becomes available only when a new policy period begins

**1054. A heating-oil tank behind an insured repair shop leaks, and oil migrates into a neighbor's soil. The neighbor sues for cleanup and property damage, and the shop tenders the suit to its CGL insurer. What is the likely coverage outcome?**

A. Covered in full as ordinary property damage

B. Denied under the CGL pollution exclusion, which removes coverage for damage caused by pollutants

C. Covered because the leak was on the insured's own land

D. Denied only if the shop was fined by regulators

**1055. A metal-finishing plant realizes its CGL policy will not respond to gradual contamination claims from its operations. What is the standard market solution for insuring this exposure?**

A. Purchase a separate pollution liability (environmental impairment liability) policy designed for pollution cleanup and third-party claims

B. Raise the CGL occurrence limit

C. Add an equipment breakdown endorsement

D. Rely on the state guaranty fund

**1056. A gas station owner installs regulated underground fuel storage tanks. Under federal environmental rules, what must the owner demonstrate, and how is insurance involved?**

A. Only that the tanks passed a one-time inspection at installation

B. That the fuel is insured against theft

C. Financial responsibility - the ability to pay for cleanup of releases and to compensate third parties for injury and property damage - which can be met by buying insurance

D. That the tanks are insured for their full replacement cost

**1057. A homeowner whose house would cost $400,000 to rebuild buys a federal flood insurance policy on a single-family residence. What is the most building coverage the National Flood Insurance Program will provide?**

A. $100,000

B. $250,000

C. $400,000

D. $500,000

**1058. The owner of a small warehouse in a floodplain wants federal flood coverage on the building. What is the maximum building limit available through the National Flood Insurance Program for a non-residential structure?**

A. $100,000

B. $250,000

C. $300,000

D. $500,000

**1059. A buyer closes on a house with a federally backed mortgage, and the lender requires flood insurance at closing. When does the new NFIP policy become effective?**

A. Immediately, because coverage required in connection with a federally backed loan is an exception to the waiting period

B. Thirty days after application and premium payment, the same as any other flood policy

C. Ten days after the deed is recorded

D. On the first day of the month following closing

**1060. Floodwaters make an insured's home uninhabitable, and the family must live in a hotel for two months during repairs. How does the family's standard NFIP flood policy respond to the hotel bills?**

A. It pays them under building coverage

B. It pays them under contents coverage

C. It does not pay them, because the NFIP policy provides no additional living expense coverage

D. It pays up to 20 percent of the building limit for loss of use

**1061. Heavy rain sends surface water across an insured's property and one neighboring property, damaging both homes. Why can this event qualify as a flood under the National Flood Insurance Program?**

A. Any water damage from weather automatically qualifies as a flood

B. The NFIP defines a flood as inundation of normally dry land affecting two or more acres or two or more properties, at least one being the policyholder's

C. A flood requires an official disaster declaration before any claim is payable

D. A flood exists only when a river or other named body of water overflows its banks

**1062. An insured owns a coastal home that would cost $700,000 to rebuild and already carries the maximum NFIP building limit. What is the usual way to close the remaining gap in flood protection?**

A. Ask FEMA to endorse the federal policy above its statutory maximum

B. Add a flood endorsement to the standard homeowners policy

C. Rely on federal disaster assistance to make up the difference

D. Purchase excess flood insurance from a private insurer over the NFIP limit

**1063. Over eighteen months, a trusted bookkeeper writes small company checks to a fake vendor she controls, stealing $60,000 before an audit uncovers the scheme. Which commercial crime insuring agreement is designed to pay this loss?**

A. Employee theft coverage

B. Inside the premises - robbery coverage

C. Computer fraud coverage

D. Forgery or alteration coverage for checks drawn against the insured by outsiders

**1064. A jewelry store owner arrives one morning to find the rear door pried open, the frame splintered, and inventory missing. No one was present overnight. In commercial crime insurance terms, this loss is best described as what?**

A. Robbery, because property was taken unlawfully

B. Burglary, because there are visible signs of forced entry into the premises

C. Mysterious disappearance, because no one saw the crime

D. Extortion, because the criminal profited from the store

**1065. A masked individual points a weapon at a cashier and demands the cash in the register, then flees with the money. In commercial crime insurance terms, this event is classified as what?**

A. Burglary

B. Safe burglary

C. Robbery, because property was taken from a person by threat of force

D. Theft by deception

**1066. A restaurant manager is carrying the night's cash deposit to the bank when she is robbed on the sidewalk. Which commercial crime insuring agreement is designed to respond?**

A. Inside the premises - theft of money and securities

B. Employee theft coverage

C. Forgery or alteration coverage

D. Outside the premises coverage, which applies to money and securities in the care of a messenger away from the premises

**1067. A company buys a commercial crime policy written on a discovery basis. Six months into the policy period, an audit reveals an employee embezzlement that actually took place two years before the policy began. How does the discovery form respond?**

A. The loss can be covered, because a discovery form applies to losses discovered during the policy period regardless of when they occurred

B. The loss is excluded, because the theft occurred before the policy period began

C. The loss is covered only if the prior insurer agrees to share it

D. The loss is covered only for the portion that occurred after the policy inception

**1068. A newly engaged homeowner owns a $20,000 engagement ring and carries a standard homeowners policy. Her agent recommends scheduling the ring on a personal articles floater. What is the main reason?**

A. The homeowners policy excludes jewelry entirely, so a floater is the only possible coverage

B. The homeowners policy applies only low special limits to theft of jewelry, while a floater insures the ring at its appraised value with broader open-perils protection

C. A floater is legally required for any single item worth more than the dwelling limit

D. Scheduling the ring reduces the homeowners premium

**1069. A fire at a dry-cleaning shop destroys hundreds of customers' garments left there for cleaning. Which inland marine coverage is designed to pay for the customers' property in the shop's care?**

A. The shop's business personal property coverage, because the garments were on its premises

B. The customers' own homeowners policies are the only source of recovery

C. Bailee's customers coverage, which protects property of others in the insured's custody

D. A contractors equipment floater

**1070. An excavation contractor keeps a bulldozer that rotates among job sites in three counties. Why is a contractors equipment floater a better fit for this machine than the contractor's commercial property policy?**

A. The commercial property policy would insure the bulldozer only against fire

B. Equipment of this value can be insured only through surplus lines carriers

C. The floater is cheaper because it excludes theft

D. Commercial property coverage is tied to described premises, while an inland marine floater follows mobile equipment wherever it is located

**1071. A furniture manufacturer regularly ships finished goods to retailers on hired trucks. A highway collision destroys a full load before delivery. Which inland marine coverage is designed for this exposure?**

A. Transit coverage insuring the goods while they are being transported

B. Ordinance or law coverage

C. Business income coverage

D. A valuable papers and records form

**1072. A broadcasting company needs property insurance on its radio transmission tower, and a toll authority needs coverage on a highway bridge. Under the Nationwide Marine Definition, why can both risks be written as inland marine?**

A. Both structures are always in motion

B. Bridges and communication towers are instrumentalities of transportation and communication, an eligible inland marine class even though they are fixed

C. Inland marine may cover any structure a standard property insurer declines

D. Both structures are considered ocean marine hulls

**1073. A producer tells a prospect, falsely, that her current insurer is about to become insolvent, and uses that claim to persuade her to cancel the policy and buy a similar one from him. Which unfair trade practice has the producer committed?**

A. Rebating

B. Coercion

C. Twisting

D. Defamation only, with no replacement violation

**1074. Every eighteen months, a producer persuades the same client to cash in policy values and use them to buy a new policy with the same insurer. The transactions serve no client need but generate first-year commissions each time. This practice is best described as what?**

A. Prudent portfolio rebalancing

B. Rebating

C. Misappropriation of premium

D. Churning

**1075. To win a commercial account, a producer offers to give the business owner half of his commission back in cash if the owner buys the policy through him. This inducement is generally known as what?**

A. Rebating, an unfair trade practice in most jurisdictions unless specifically permitted

B. A lawful discount available to any producer

C. Twisting

D. A fiduciary distribution

**1076. A producer collects a client's premium check, deposits it in his personal account, and uses part of it to cover office rent, planning to forward the balance to the insurer next month. What standard has the producer violated?**

A. None, provided the insurer eventually receives the full premium

B. His fiduciary duty, because collected premiums are trust funds that belong to others and must not be commingled or used as his own

C. Only an internal accounting guideline with no regulatory significance

D. The rule against rebating

**1077. A client asks her producer to add a newly purchased building to her commercial policy. The producer forgets, and an uninsured fire loss follows. The client sues the producer for the unpaid loss. Which coverage protects the producer against this claim?**

A. The producer's own commercial general liability policy

B. The insurer's errors are always absorbed by the insurer, so no producer coverage is needed

C. Errors and omissions insurance, which covers financial harm caused by the producer's negligent professional mistakes

D. A fidelity bond

**1078. Before the federal flood program existed, private insurers largely refused to write flood coverage on homes because a single storm could damage thousands of insured properties in the same area at once. Which element of an ideally insurable risk does flood fail?**

A. The loss must be accidental

B. The premium must be economically feasible

C. The loss must be definite as to time and place

D. The loss must not be catastrophic to the insurer, meaning exposure units should not all suffer loss at the same time

**1079. An insurer that writes 500,000 similar homes can predict its annual fire losses far more accurately than an insurer writing 500 similar homes. Which principle explains this?**

A. The law of large numbers - as the number of similar exposure units grows, actual results approach expected results

B. The principle of indemnity

C. Adverse selection

D. The principle of subrogation

**1080. After several injury claims, a family entertainment center permanently shuts down its trampoline attraction rather than continue operating it. Which risk management technique has the business used?**

A. Retention

B. Avoidance - eliminating the activity that creates the loss exposure

C. Transfer

D. Reduction

**1081. A commercial insurance buyer notices that renewal premiums are rising sharply, insurers are tightening underwriting standards, and some carriers are declining classes of business they wrote easily two years earlier. Which phase of the insurance market cycle does this describe?**

A. A soft market

B. A residual market

C. A hard market, marked by rising rates, restricted terms, and reduced capacity

D. A run-off market

**1082. A primary insurer heavily concentrated in coastal homeowners business cedes part of that book to another insurer under a treaty. What is the primary insurer accomplishing?**

A. Eliminating its policyholder obligations, which pass directly to the other insurer

B. Converting its policies into surplus lines business

C. Rebating premium to its policyholders

D. Buying reinsurance, which transfers part of its assumed risk so it can protect itself from catastrophic losses and write more business

**1083. A city hires a contractor to rebuild a public road and requires the contractor to post a surety bond guaranteeing completion. Halfway through, the contractor abandons the job. Whom does the bond protect?**

A. The city, as obligee, which is compensated or has the work completed when the principal defaults

B. The contractor, who is excused from performing

C. The surety, which keeps the premium

D. The contractor's employees, who are guaranteed wages

**1084. A surety pays a project owner $200,000 after the bonded contractor defaults. What happens next, and why does this show that a surety bond is not true insurance?**

A. The surety absorbs the loss the way an insurer pays a claim, because the premium was calculated to fund expected losses

B. The surety seeks reimbursement from the contractor, because the bond premium is a service fee and the principal remains ultimately responsible for its own default

C. The surety bills the project owner for the shortfall

D. The loss is split equally among all three parties to the bond

**1085. A contractor submits the winning bid on a school project but then refuses to sign the contract at its bid price, forcing the district to award the job to the next lowest bidder at a higher cost. Which bond is designed to compensate the district for that difference?**

A. A payment bond

B. A performance bond

C. The bid bond the contractor posted with its proposal

D. A maintenance bond

**1086. An employer wants protection against dishonest acts by its own cashiers, while a licensing board wants a guarantee that a contractor will comply with its obligations to the public. Which statement correctly matches each need to the right instrument?**

A. Both needs call for surety bonds, since bonds always involve dishonesty

B. The employer needs a surety bond and the board requires a fidelity bond

C. The employer needs a fidelity bond covering employee dishonesty, while the board requires a surety bond guaranteeing the contractor's obligation to a third party

D. Both needs are met by an errors and omissions policy

# Answer key with explanations

**1. B**

Transacting insurance without a valid license is a misdemeanor in California punishable by a fine of not more than $50,000, imprisonment in a county jail for not more than one year, or both. The $5,000 and $10,000 figures are the civil penalties for unfair practices under the Unfair Practices Act, not the unlicensed-transaction penalty. See Cal. Ins. Code 1633.

**2. C**

For buyers under age 60, California requires every individual life policy to carry a notice that the owner may return it for cancellation, and the return period the insurer chooses must be not less than 10 days nor more than 30 days. On a nonvariable policy the insurer must refund all premiums and any policy fee within 30 days of being told the owner canceled. The 30-day minimum applies only to senior citizens under a separate section. See Cal. Ins. Code 10127.9.

**3. A**

For life policies and annuities, California defines a senior citizen as an individual who is 60 years of age or older on the date of purchase, and the return period stated in the notice must be not less than 30 days. During that 30-day period a variable contract's premium must be held in a fixed account or money-market fund unless the owner directs otherwise. Age 65 is the threshold used for the separate disability (health) senior free-look rule. See Cal. Ins. Code 10127.10.

**4. D**

California requires individual life policies to provide a grace period of not less than 60 days from the premium due date, with the policy remaining in force during that time. A policy may not lapse for nonpayment unless the insurer mails notice to the owner, any designee named under Section 10113.72, and any known assignee at least 30 days before the effective date of termination. The 30- and 31-day grace periods belong to other lines and other states. See Cal. Ins. Code 10113.71.

**5. B**

No individual life policy may be issued or delivered in California until the applicant has been given the right to designate at least one person, in addition to the applicant, to receive notice of lapse or termination for nonpayment. The insurer must remind the owner annually of the right to change that designee, and must give the owner and designee at least 30 days' notice before any lapse. See Cal. Ins. Code 10113.72.

**6. C**

Where replacement is involved, the agent must present the Notice Regarding Replacement to the applicant not later than at the time of taking the application, have it signed by both the applicant and the agent, and leave a copy with the applicant. The agent must also obtain a list of every existing life policy or annuity to be replaced, identified by insurer, insured and contract number. See Cal. Ins. Code 10509.4.

**7. A**

The replacing insurer must send each existing life insurer a written communication advising of the proposed replacement within three working days of the date the application is received. The owner of the replacement policy has a right to an unconditional refund of all premiums paid, exercisable within 30 days from the date of delivery, and the insurer must keep evidence of compliance for at least three years. See Cal. Ins. Code 10509.6.

**8. D**

A life agent must complete eight hours of annuity training before soliciting individual consumers to sell annuities, and four hours of training before each license renewal thereafter; the initial eight hours do not satisfy the renewal requirement. The course must cover annuities, California law, prohibited sales practices, and recognizing cognitive indicators in prospective buyers. These hours count toward, and do not increase, the agent's regular continuing education total. See Cal. Ins. Code 1749.8.

**9. B**

A person who meets with a senior in the senior's home to sell insurance must deliver a written notice no less than 24 hours and no more than 14 days before the initial meeting. The notice is a stand-alone document in 16-point bold type showing the agent's licensed name, license number, address and phone number, the purpose of the visit, the senior's right to have others present or end the meeting, and the names of everyone who will attend. See Cal. Ins. Code 789.10.

**10. C**

The association pays 80 percent of an insolvent insurer's contractual obligations, subject to caps of $300,000 in life insurance death benefits but not more than $100,000 in net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, and an aggregate of $300,000 in benefits with respect to any one life. The health benefit cap is a separate $200,000 figure indexed to health-care inflation since 1991. See Cal. Ins. Code 1067.02.

**11. A**

California's group life conversion provision lets a terminated employee apply and pay the first premium for an individual policy within 31 days after termination, in an amount equal to the group coverage that ended, without evidence of insurability. If the employee is not told of the conversion right at least 15 days before that deadline, an extra period of 25 days after notice applies, but never beyond 60 days after the original deadline. If the employee dies during the 31-day period, the convertible amount is paid as a claim under the group policy. See Cal. Ins. Code 10209.

**12. D**

Insurers and agents must keep the original application, premium and commission records, correspondence, benefit comparisons and outlines of coverage for a minimum of five years following actual delivery of the policy, or, if no policy was issued, five years after the date of application. Originals or certified copies must be delivered to the Commissioner within 30 days of a written demand. See Cal. Ins. Code 10508.

**13. B**

The Code lists the acceptable delivery methods for a life policy as registered or certified mail, personal delivery with a signed written receipt, first-class mail with a signed written receipt, or other reasonable means approved by the Commissioner. If the insurer uses some other method, the burden is on the insurer to prove delivery, and a policy is deemed received six months after the date of issuance if premiums have been paid. See Cal. Ins. Code 10113.6.

**14. B**

The Commissioner may deny a license if the applicant is not properly qualified, is not of good business reputation, is lacking in integrity, or does not intend actively and in good faith to carry on the insurance business. Character grounds alone support denial. See Cal. Ins. Code 1668.

**15. C**

The Commissioner may deny an application if, within the past five years, the applicant had a previous application for a professional, occupational, or vocational license denied for cause, or had such a license suspended or revoked for cause. See Cal. Ins. Code 1669.

**16. A**

A licensee may not act as an agent of an insurer unless the insurer has filed a notice of appointment, and the authority granted by the appointment is effective as of the date the notice of appointment is signed. It continues until the license terminates or a notice of termination is filed. See Cal. Ins. Code 1704.

**17. D**

All premium and return premium funds received by a licensee are received and held in a fiduciary capacity, and diversion or appropriation of those fiduciary funds to the licensee's own use is theft. See Cal. Ins. Code 1733.

**18. B**

A licensee who does not immediately remit fiduciary funds must maintain them at all times in a trust account, separate from other accounts, in a bank or savings institution insured by the FDIC, in an amount at least equal to net premiums and return premiums received but unremitted. See Cal. Ins. Code 1734.

**19. A**

No person may make a misleading representation or comparison of insurers or policies to an insured for the purpose of inducing the insured to lapse, forfeit, change, or surrender insurance. This is the conduct commonly called twisting. See Cal. Ins. Code 781.

**20. C**

Since January 1, 2026, California's former 20-hour per-line prelicensing courses are repealed (AB 943). What remains is a 12-hour course on ethics and the California Insurance Code, including one hour on insurance fraud - and per the Department of Insurance, it must be completed before the license can be issued, not before scheduling or taking the examination. See Cal. Ins. Code 1749 and the CDI prelicensing FAQ.

**21. D**

Under the senior insurance article, all advertisements used by agents, producers, brokers, or solicitors for an insurer's policy must have the written approval of the insurer before they may be used. An agent contacting a prospect from a lead-generating device must also disclose that fact in the initial contact. See Cal. Ins. Code 787.

**22. A**

A producer must have reasonable grounds to believe an annuity recommendation is suitable and that the consumer would receive a tangible net benefit, and neither a producer nor an insurer may recommend that a person 65 or older replace an existing annuity when the purchase does not confer a substantial financial benefit. The restriction applies where the annuity being replaced carries a surrender charge. See Cal. Ins. Code 10509.914.

**23. B**

A policy subject to surrender charges or penalties must carry a notice, printed in bold 12-point type on the front of the policy jacket or on the cover page, identifying where the surrender charge, its time period, and any penalties are located in the policy. See Cal. Ins. Code 10127.13.

**24. C**

Insurable interest is an interest based on a reasonable expectation of pecuniary advantage through the continued life, health, or bodily safety of another. It must exist at the time the contract becomes effective, but need not exist at the time the loss occurs. See Cal. Ins. Code 10110.1.

**25. B**

An individual life policy must be incontestable after it has been in force, during the insured's lifetime, for not more than two years from its date of issue, except for nonpayment of premiums and certain supplemental benefit provisions. After two years only those exceptions remain. See Cal. Ins. Code 10113.5.

**26. A**

If life insurance proceeds are not paid within 30 days after the date of death, the insurer must pay interest from the date of the insured's death, at a rate not less than the current rate paid on death proceeds left on deposit with the insurer. See Cal. Ins. Code 10172.5.

**27. D**

The owner may rescind a life settlement contract within 30 days of the date it is executed by all parties and all required disclosures are received, or within 15 days of the owner's receipt of the settlement proceeds, whichever is sooner, provided proceeds and premiums are repaid. See Cal. Ins. Code 10113.2.

**28. B**

A life policy, with the endorsed or attached application, constitutes the entire contract, and all statements purporting to be made by the insured are, in the absence of fraud, representations and not warranties. Any waiver of this section is void. See Cal. Ins. Code 10113.

**29. A**

All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older a duty of honesty, good faith, and fair dealing, in addition to any other duties imposed by law. See Cal. Ins. Code 785.

**30. C**

A life or disability income insurer that asks an applicant to undergo an HIV test must obtain the applicant's written informed consent, which must describe the test, its purpose, potential uses and limitations, the meaning of results, notification procedures, and the right to confidential treatment. See Cal. Ins. Code 799.03.

**31. C**

The required grace-period provision for disability policies is at least 7 days for weekly-premium policies, 10 days for monthly-premium policies, and 31 days for all other premium modes, with the policy continuing in force during the grace period. The 60-day figure is the grace period California requires for individual life policies, not disability policies. See Cal. Ins. Code 10350.3.

**32. B**

The mandatory notice-of-claim provision requires written notice within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as is reasonably possible. Where disability benefits may be payable for at least two years, the insured must also give notice of continuance at least once every six months. Ninety days is the deadline for written proof of loss, not notice of claim. See Cal. Ins. Code 10350.5.

**33. D**

Written proof of loss must be furnished within 90 days after the date of loss, or for periodic-payment claims within 90 days after the end of the period for which the insurer is liable. Late proof does not invalidate the claim if it was not reasonably possible to file on time, provided it is furnished as soon as reasonably possible and, except where the claimant lacks legal capacity, no later than one year from the time proof was otherwise due. See Cal. Ins. Code 10350.7.

**34. A**

The required claim-forms provision says that if the insurer does not furnish its usual proof-of-loss forms within 15 days after notice of claim is given, the claimant is deemed to have complied with the proof-of-loss requirement by submitting, within the time fixed for proof of loss, written proof covering the occurrence, character and extent of the loss. See Cal. Ins. Code 10350.6.

**35. B**

The required provision makes the policy incontestable as to statements contained in the application after it has been in force for two years during the lifetime of the insured, excluding any period during which the insured is disabled. One year and three years are figures from other states' provisions, not California's. See Cal. Ins. Code 10350.2.

**36. C**

Disability policies and certificates issued to individuals age 65 or older in California must allow an examination period of 30 days after receipt during which the buyer may return the policy for a full refund of premiums and fees. The insurer must refund within 30 days after it receives the returned policy, or interest at the legal rate on judgments begins to accrue. Note the age trigger here is 65, whereas the life-insurance senior free-look uses age 60. See Cal. Ins. Code 786.

**37. A**

An insurer may not deny or condition a Medicare supplement policy, or discriminate in pricing because of health status, during the six-month period beginning with the first day of the first month in which the applicant is both 65 years of age or older and enrolled for benefits under Medicare Part B. Under-65 individuals enrolled in Medicare by reason of disability get a comparable window. California also requires an annual open enrollment of at least 60 days starting on the insured's birthday, during which they may switch to a plan with equal or lesser benefits. See Cal. Ins. Code 10192.11.

**38. D**

First-year commission or other first-year compensation on a Medicare supplement policy may be no more than 200 percent of the commission paid for selling or servicing the policy in the second year, and the compensation in later renewal years must equal the second-year amount and be provided for no fewer than five renewal years. See Cal. Ins. Code 10192.16.

**39. B**

An eligible person, which includes someone whose employee welfare benefit plan stops providing benefits supplemental to Medicare, is entitled to guaranteed issue of a Medicare supplement policy if the application is submitted within 63 days after the prior coverage terminates. Other eligible persons include those disenrolled from a terminated Medicare Advantage plan and those who left a Medicare supplement policy for Medicare Advantage and disenroll within 12 months. See Cal. Ins. Code 10192.12.

**40. C**

Agents licensed after January 1, 1992 must complete eight hours of long-term care training in each of the first four 12-month periods of licensure and, after that, eight hours before each license renewal; agents licensed before 1992 need eight hours before each renewal. The section also bars marketing methods that hide the fact that an agent or insurer will follow up. These LTC hours count toward the agent's normal continuing-education total rather than adding to it. See Cal. Ins. Code 10234.93.

**41. A**

Life and accident and health or sickness agents must complete 24 hours of continuing education before renewal, three hours of which must be in ethics; since March 1, 2023 the ethics course includes one hour on insurance fraud. An agent who also holds a property and casualty broker-agent license satisfies both with a combined 24 hours, not 48. See Cal. Ins. Code 1749.33.

**42. D**

Every applicant and licensee must notify the Commissioner in writing within 30 days of learning of any change in background information, which includes criminal convictions and charges, administrative actions by any regulator, bankruptcy discharges involving insurance obligations, and findings of fraud or breach of fiduciary duty. Note the contrast with a change of address, which must be reported immediately under Section 1729. See Cal. Ins. Code 1729.2.

**43. B**

The policy, including endorsements and attached papers, constitutes the entire contract of insurance. No change is valid until approved by an executive officer of the insurer and endorsed on or attached to the policy, and no agent has authority to change the policy or waive its provisions. See Cal. Ins. Code 10350.1.

**44. C**

A reinstated disability policy covers only loss from accidental injury sustained after the date of reinstatement, and loss due to sickness that begins more than 10 days after that date. Sickness beginning on day five is excluded; the later accidental injury is covered. See Cal. Ins. Code 10350.4.

**45. A**

Indemnities for losses other than periodic-payment losses are paid immediately on receipt of written proof of loss, and accrued indemnities for loss for which the policy provides periodic payment must be paid not less frequently than monthly, with any balance paid promptly when liability ends. See Cal. Ins. Code 10350.8.

**46. D**

Indemnity for loss of life is payable in accordance with the effective beneficiary designation; if no designation or provision is then effective, it is payable to the estate of the insured. All other indemnities are payable to the insured. See Cal. Ins. Code 10350.9.

**47. B**

The insurer, at its own expense, has the right and opportunity to examine the person of the insured when and as often as it may reasonably require while a claim is pending, and to make an autopsy in case of death where not forbidden by law. See Cal. Ins. Code 10350.10.

**48. C**

No action at law or in equity may be brought to recover on the policy before the expiration of 60 days after written proof of loss has been furnished, nor after the expiration of three years after the time written proof of loss is required to be furnished. See Cal. Ins. Code 10350.11.

**49. D**

Unless the insured has made an irrevocable designation, the right to change of beneficiary is reserved to the insured, and the consent of the beneficiary or beneficiaries is not requisite to a change of beneficiary or other policy changes. See Cal. Ins. Code 10350.12.

**50. A**

A policy must provide immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured, and to each minor child placed for adoption, and coverage may not be disclaimed or limited for those children. See Cal. Ins. Code 10119.

**51. B**

An insurer must reimburse a complete claim, or portion of one, as soon as practicable but no later than 30 calendar days after receipt, or send written notice within 30 calendar days that the claim is contested or denied. Interest accrues at 15 percent per annum beginning the first calendar day after the 30-day period. See Cal. Ins. Code 10123.13.

**52. C**

The applicant may return a long-term care policy or certificate by first-class mail within 30 days of its delivery, and all premiums and any policy fee must be fully refunded within 30 days after the return. Notice of this right must appear prominently on the first page. See Cal. Ins. Code 10232.7.

**53. D**

An individual LTC policy may not be issued until the applicant may designate at least one additional person to receive notice of lapse; the notice goes by first-class mail not less than 30 days after a premium is due and unpaid, and reinstatement must be available within five months of termination on proof of cognitive impairment or loss of functional capacity. See Cal. Ins. Code 10235.40.

**54. A**

No LTC policy or certificate may be delivered or issued in California unless the insurer offers the option to purchase inflation protection, including at least one option that increases benefit levels annually, compounded at a rate of not less than 5 percent. See Cal. Ins. Code 10237.1.

**55. C**

A group health benefit plan, and a nongrandfathered individual health benefit plan, may not impose any preexisting condition provision or waivered condition provision on any individual, and group or individual plans may not impose a waiting period. See Cal. Ins. Code 10198.7.

**56. B**

For violations of the article protecting seniors, an insurer is liable for an administrative penalty of $10,000 for a first violation, and $30,000 to $300,000 for subsequent or knowing violations; a broker or agent faces at least $1,000, then $5,000 to $50,000. The Commissioner may also order rescission of the contract. See Cal. Ins. Code 789.3.

**57. D**

The Commissioner shall not approve a disability policy form that is unintelligible, uncertain, ambiguous, abstruse, or likely to mislead, or where a benefit, or the benefits as a whole, are not sufficient to be of real economic value to the insured. See Cal. Ins. Code 10291.5.

**58. A**

An individual health policy may be terminated only on specified grounds such as nonpayment of premium (with at least a 30-day grace period), demonstrated fraud or intentional misrepresentation of material fact, movement outside the service area, or withdrawal of the plan or insurer from the market - not because of claims experience or health status. See Cal. Ins. Code 10273.6.

**59. C**

A Medicare supplement policy or certificate must give the insured the right to return it within 30 days of receipt and have the full premium refunded if not satisfied for any reason; the return voids the policy from the beginning, and late refunds accrue interest. See Cal. Ins. Code 10192.17.

**60. B**

Cal-COBRA continuation coverage under an insured group plan runs until the date 36 months after the qualified beneficiary's benefits would otherwise have terminated because of the qualifying event, subject to earlier termination events specified in the statute. See Cal. Ins. Code 10128.57.

**61. B**

Effective January 1, 2025, Vehicle Code 16056 raised California's minimum limits to $30,000 for bodily injury or death of one person, $60,000 for two or more persons in one accident, and $15,000 for property damage. The old 15/30/5 limits no longer satisfy the law, and the statute schedules a further increase to 50/100/25 beginning January 1, 2035. See Cal. Veh. Code 16056.

**62. C**

Proposition 103 requires every insurer to offer a Good Driver Discount policy to eligible drivers at a rate at least 20 percent below the rate the insured would otherwise be charged for the same coverage. The same section lists the three mandatory rating factors in decreasing order of importance: driving safety record, annual miles driven, and years of driving experience. See Cal. Ins. Code 1861.02.

**63. A**

A good driver must have been licensed to drive for the previous three years and, during that period, must not have had more than one violation point under Vehicle Code 12810, and must not have been convicted of a DUI offense (Vehicle Code 23140, 23152 or 23153) within the ten years before the application. See Cal. Ins. Code 1861.025.

**64. D**

A notice of cancellation of an automobile policy is not effective unless mailed or delivered to the named insured, lienholder or additional interest at least 20 days before the effective date. When the cancellation is for nonpayment of premium, only 10 days' notice is required. Thirty days is the nonrenewal notice period, not the cancellation period. See Cal. Ins. Code 662.

**65. B**

Before an automobile policy expires the insurer must give either a written notice of nonrenewal at least 30 days before expiration, or a written or verbal offer of renewal at least 20 days before expiration contingent on payment of premium. The 45- and 75-day figures belong to residential property policies. See Cal. Ins. Code 663.

**66. C**

An automobile policy may be cancelled only for nonpayment of premium; suspension or revocation of the driver's license or vehicle registration of the named insured or a household operator during the policy period or the preceding 180 days; discovery of fraud in pursuing a claim; material misrepresentation of the driving record, annual mileage, driving experience or prior claims; or a substantial increase in the hazard insured against. Filing a claim is not a listed ground. See Cal. Ins. Code 661.

**67. D**

For residential property policies expiring on or after July 1, 2020, the insurer must mail or deliver a notice of nonrenewal or of conditional renewal at least 75 days before expiration; subdivision (a)'s older 45-day figure was extended to 75 days by subdivision (c). If the insurer gives neither an offer to renew nor a nonrenewal notice in time, the existing policy continues with no change in terms until the required period after the notice is finally mailed or delivered. See Cal. Ins. Code 678.

**68. A**

After a residential property policy has been in effect for 60 days, or immediately if it is a renewal, cancellation is limited to nonpayment of premium; conviction of the named insured of a crime that increases a hazard insured against; fraud or material misrepresentation in obtaining the insurance or pursuing a claim; grossly negligent acts that substantially increase a hazard; or physical changes in the property that make it uninsurable. Market withdrawal or claims filing are not permitted cancellation grounds and must be handled through nonrenewal. See Cal. Ins. Code 676.

**69. B**

For the commercial policies covered by the section, the insurer must deliver or mail notice of nonrenewal at least 60 days, but not more than 120 days, before the end of the policy period. If the insurer fails to give the notice on time, the policy continues with no change in terms for 60 days after the notice is finally given. Seventy-five days is the residential-property figure. See Cal. Ins. Code 678.1.

**70. C**

After a declared state of emergency, an insurer must offer a 60-day grace period for payment of premiums on residential property policies covering property within the affected area, for a period of 60 days after the emergency. The insurer may also reinstate a policy cancelled during that time without a lapse or late fees if the policyholder asks and pays what is owed in a reasonably timely manner. See Cal. Ins. Code 2062.

**71. D**

Every bodily injury liability policy issued in California must include uninsured motorist coverage at least equal to the financial responsibility minimums unless the named insured rejects it in a written agreement in the statutory form. The insurer is not required to offer UM limits above $30,000 per person and $60,000 per accident, although it may offer higher limits up to the underlying liability limits. See Cal. Ins. Code 11580.2.

**72. A**

A covered claim does not include the portion of any claim, other than a workers' compensation claim, that exceeds $500,000, and does not include claims of $100 or less. Workers' compensation benefits are paid in full under the workers' compensation law. The $300,000 figure is the life and health guarantee association's death-benefit cap, a different fund. See Cal. Ins. Code 1063.1.

**73. B**

Workers' compensation fraud is punishable by imprisonment in county jail for one year or in state custody for two, three or five years, by a fine not exceeding $150,000 or double the value of the fraud, whichever is greater, or by both, plus restitution. The $50,000 figure is the fine for transacting insurance without a license. See Cal. Ins. Code 1871.4.

**74. C**

Upon receiving proof of claim, every insurer must immediately, but in no event more than 40 calendar days later, accept or deny the claim in whole or in part; if more time is needed it must say so in writing within that period and every 30 calendar days thereafter. Once a claim is accepted, payment must be tendered immediately and no later than 30 calendar days. See 10 Cal. Code Regs. 2695.7.

**75. A**

Upon receiving any communication from a claimant that reasonably suggests a response is expected, the licensee must furnish a complete response immediately and in no event more than 15 calendar days after receipt. The same 15-day clock applies to acknowledging a new notice of claim, providing forms and instructions, and beginning the investigation. Forty days is the deadline to accept or deny a claim. See 10 Cal. Code Regs. 2695.5.

**76. D**

Any person who engages in an unfair method of competition or unfair or deceptive act or practice defined in Section 790.03 is liable for a civil penalty not to exceed $5,000 for each act, or not to exceed $10,000 for each act if the act or practice was willful. The penalty is imposed and determined by the Commissioner and may be appealed. See Cal. Ins. Code 790.035.

**77. B**

A property or casualty broker-agent must complete 24 hours of instruction before renewal, of which three hours must be in ethics; since March 1, 2023 the ethics course must include one hour of study on insurance fraud. The 12 hours of ethics and Code study is a one-time prelicensing requirement, not continuing education, and licensees with 30 continuous years who are age 70 or older may be exempt unless first licensed on or after January 1, 2010. See Cal. Ins. Code 1749.3.

**78. C**

Licensees must print their license number on business cards, written price quotations, and print advertisements distributed exclusively in California, in type at least as large as any phone number or address, and include the word Insurance. The penalty is $200 for the first offense, $500 for the second, and $1,000 for the third and later offenses, although the Commissioner may waive it for reasonable cause. See Cal. Ins. Code 1725.5.

**79. A**

Proposition 103 made California a prior approval state: commencing November 8, 1989, insurance rates subject to the chapter must be approved by the Commissioner prior to their use. The initiative also required a rollback to at least 20 percent below November 8, 1987 charges. See Cal. Ins. Code 1861.01.

**80. C**

No rate may be approved or remain in effect that is excessive, inadequate, or unfairly discriminatory, and on timely request the Commissioner must hold a hearing when a proposed rate increase exceeds 7 percent for personal lines or 15 percent for commercial lines. See Cal. Ins. Code 1861.05.

**81. B**

No policy of residential property insurance may be issued, delivered, or initially renewed in California unless the named insured is offered coverage for loss or damage caused by the peril of earthquake. The insured may decline, but the offer is mandatory. See Cal. Ins. Code 10081.

**82. D**

The Insurance Code creates the California Earthquake Authority, administered and governed by a governing board under public oversight, to sell basic residential earthquake policies. It is funded through premiums, with operating expenses capped at 6 percent of premium income. See Cal. Ins. Code 10089.6.

**83. C**

Every employer must secure the payment of compensation either by being insured with one or more insurers duly authorized to write compensation insurance in California, or by securing a certificate of consent to self-insure from the Director of Industrial Relations. See Cal. Lab. Code 3700.

**84. A**

A driver involved in an accident causing damage to the property of any one person in excess of $1,000, or bodily injury or death, must report the accident to the DMV within 10 days. See Cal. Veh. Code 16000.

**85. B**

A policy under the low-cost automobile insurance program provides limits of $10,000 for bodily injury or death per person, $20,000 per accident, and $3,000 for property damage - lower than the standard financial responsibility limits. See Cal. Ins. Code 11629.71.

**86. C**

The standard form fire policy requires that suit be commenced within 12 months after inception of the loss, extended to 24 months for losses related to a declared state of emergency. The insured must also render a signed, sworn proof of loss within 60 days. See Cal. Ins. Code 2071.

**87. D**

Notice of cancellation of a commercial policy must be given at least 30 days before the effective date, except that for cancellation based on nonpayment of premium or fraud the notice must be given no less than 10 days before, delivered to the named insured and the producer of record. See Cal. Ins. Code 677.2.

**88. A**

Basic property insurance under the FAIR Plan means insurance against direct loss to real or tangible personal property at a fixed location, from perils insured under the standard fire policy and extended coverage endorsement, plus vandalism and malicious mischief. It does not insure automobile risks. See Cal. Ins. Code 10091.

**89. C**

The statute enumerates 16 unfair claims settlement practices, including failing to acknowledge and act reasonably promptly on claim communications and not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear. See Cal. Ins. Code 790.03.

**90. D**

Any person engaged in processing, presenting, or negotiating claims who offers, delivers, receives, or accepts any rebate, refund, commission, or other consideration for the referral or procurement of clients or customers is guilty of a crime, punishable on first conviction by up to one year in county jail and/or a fine of up to $50,000. See Cal. Ins. Code 750.

**91. A**

The primary purpose of life insurance is to provide financial protection to beneficiaries (such as family members) when the insured person dies. While some policies have cash value components, the core function is death benefit protection.

**92. B**

The insured is the person whose life is covered by the insurance policy. Upon their death, the death benefit is paid to the beneficiary.

**93. C**

A premium is the amount paid by the policyholder to the insurance company to keep the policy in force. Premiums can be paid monthly, quarterly, semi-annually, or annually.

**94. D**

The face amount (also called face value) is the death benefit amount stated in the policy that will be paid to beneficiaries upon the insured's death.

**95. A**

Insurable interest means having a financial stake in the continued life of the insured. It must exist at the time of policy application to prevent insurance from being used for speculation or harm.

**96. B**

Insurable interest must exist at the time of application (inception of the policy). It does not need to continue throughout the policy period or at the time of death.

**97. C**

The grace period (typically 30-31 days) is the time after a premium due date during which the premium can be paid without the policy lapsing. Coverage continues during this period.

**98. D**

The standard grace period for life insurance policies is 30-31 days. During this time, the policy remains in force even if the premium hasn't been paid.

**99. A**

Term life insurance provides coverage for a specific period (term) such as 10, 20, or 30 years. If the insured dies during the term, beneficiaries receive the death benefit. If the term expires and the insured is still alive, coverage ends.

**100. B**

Whole life insurance is a permanent policy that includes both a death benefit and a cash value component that grows over time at a guaranteed rate. Term insurance does not have cash value.

**101. C**

Universal life insurance is a type of permanent life insurance that offers flexibility in premium payments and death benefit amounts. It also has a cash value component that earns interest.

**102. D**

Variable life insurance allows the policyholder to invest the cash value in various sub-accounts (similar to mutual funds). This means both cash value and death benefit can fluctuate based on investment performance.

**103. A**

Decreasing term life insurance has a death benefit that decreases over time. It's commonly used to cover debts that decrease over time, such as a mortgage balance.

**104. B**

A convertible term policy allows the policyholder to convert their term coverage to a permanent policy (like whole life) without providing evidence of insurability. This protects the insured if their health declines.

**105. C**

Whole life insurance provides permanent coverage for the insured's entire life and accumulates cash value. Term life provides temporary coverage for a specific period and has no cash value component.

**106. D**

Renewable term insurance allows the policyholder to renew the policy at the end of the term without providing evidence of insurability. Premiums typically increase with each renewal based on the insured's attained age.

**107. A**

Once a life policy has been in force for the contestable period, commonly two years, the insurer can no longer contest the policy or deny a claim because of misstatements in the application. Nonpayment of premium is never barred by the clause. A minority of states preserve a narrow exception for fraudulent misstatements, so the protection is close to but not absolutely universal.

**108. B**

The suicide clause applies only during a stated period after issue - typically the first two years. If the insured dies by suicide within that period, the insurer does not pay the face amount; it refunds the premiums paid (some policies add interest). After the period ends, suicide is a covered cause of death, so option C is wrong. Option A describes the contestability provision, and option D describes a graded-benefit design, not the suicide clause.

**109. C**

A policy loan allows the policyholder to borrow money from the insurance company using the policy's cash value as collateral. Interest is charged on the loan, and unpaid loans reduce the death benefit.

**110. D**

The waiver of premium rider allows premium payments to be waived if the insured becomes totally disabled for a specified period. The policy remains in force without premium payments during the disability.

**111. A**

An accelerated death benefit rider allows the insured to receive a portion of the death benefit early if diagnosed with a terminal illness. This provides funds for medical expenses or other needs while still living.

**112. B**

The guaranteed insurability rider (also called guaranteed purchase option) allows the insured to purchase additional coverage at specified future dates or events without having to prove insurability again.

**113. C**

The accidental death benefit rider (sometimes called 'double indemnity') pays an additional death benefit, often equal to the face amount, if the insured dies as a result of an accident.

**114. D**

The free look period (typically 10-30 days depending on state) allows the policyholder to review the policy after delivery. If unsatisfied, they can return the policy for a full refund of premiums paid.

**115. A**

A primary beneficiary is the person or persons first in line to receive the death benefit when the insured dies. Only if the primary beneficiary predeceases the insured or is otherwise disqualified from taking does the benefit pass to the contingent (secondary) beneficiary; if the primary beneficiary is alive but cannot be found, the insurer holds the proceeds and ultimately reports them as unclaimed property under state law.

**116. B**

A contingent (or secondary) beneficiary receives the death benefit proceeds if the primary beneficiary predeceases the insured or is otherwise unable to receive the benefit.

**117. C**

A revocable beneficiary can be changed by the policyowner at any time without the beneficiary's consent. This is the most common type of beneficiary designation.

**118. D**

An irrevocable beneficiary has a vested interest in the policy and cannot be changed without their written consent. This limits the policyowner's flexibility in making policy changes.

**119. A**

The lump sum settlement option pays the entire death benefit to the beneficiary in one single payment. This is the most common and straightforward settlement option.

**120. B**

Under the interest only option, the insurance company retains the death benefit principal and pays the beneficiary only the interest earned. The beneficiary can later choose how to receive the principal.

**121. C**

The fixed period (installments for a fixed period) settlement option pays the death benefit in equal installments over a specified number of years until the principal and interest are exhausted.

**122. D**

The life income settlement option provides periodic payments to the beneficiary for their entire lifetime. The payment amount depends on the death benefit amount and the beneficiary's age.

**123. A**

Underwriting is the process by which insurance companies evaluate applications, assess risk factors, determine if coverage will be offered, and set appropriate premium rates.

**124. B**

Standard risk classification means the applicant presents an average level of risk and qualifies for standard (normal) premium rates. They are neither preferred (better than average) nor substandard (higher risk).

**125. C**

A substandard (or rated) policy is issued to applicants who present higher-than-average risk due to health conditions, occupation, or lifestyle. They pay higher premiums to compensate for the increased risk.

**126. D**

Adverse selection is the tendency for people who represent higher risks (poor health, dangerous occupations) to seek insurance more often than those with lower risks. Underwriting helps counteract this tendency.

**127. A**

The MIB is a cooperative database used by insurers to share coded medical information about insurance applicants. It helps detect fraud and ensures accurate underwriting across the industry.

**128. B**

Preferred risk classification is given to applicants who present better-than-average risk factors (excellent health, non-smoker, healthy lifestyle). They qualify for lower premium rates.

**129. C**

Life insurance death benefits paid to beneficiaries are generally received income tax-free. This is one of the key tax advantages of life insurance.

**130. D**

Cash value withdrawals are taxed on a FIFO (First-In, First-Out) basis. Withdrawals up to the total premiums paid (basis) are tax-free. Amounts exceeding basis are taxed as ordinary income.

**131. A**

A MEC is a life insurance policy that has been funded too quickly (fails the 7-pay test) and loses some tax advantages. Withdrawals and loans from MECs may be subject to ordinary income tax and a 10% penalty if taken before age 59.

**132. B**

Premiums on personal life insurance are not deductible, because the death benefit is received income-tax free. Employer-paid group term life premiums are fully deductible to the employer as a business expense. Separately, only the cost of the first $50,000 of that group coverage is excluded from the employee's income; the cost of coverage above $50,000 is imputed to the employee as taxable wages.

**133. C**

An annuity is a contract between an individual and an insurance company where the individual pays premiums and the insurer provides periodic income payments, typically for retirement.

**134. D**

A fixed annuity provides a guaranteed minimum interest rate during the accumulation phase and fixed periodic payments during the payout phase. The insurance company bears the investment risk.

**135. A**

A variable annuity allows the owner to invest in sub-accounts (similar to mutual funds). The accumulation value and income payments vary based on investment performance. The owner bears the investment risk.

**136. B**

The accumulation period (also called pay-in period) is when the annuity owner pays premiums and the account value grows through interest or investment returns before income payments begin.

**137. C**

Annuitization is when the accumulated value is converted into periodic income payments. Once annuitized, the contract typically cannot be reversed or surrendered for cash value.

**138. D**

A life annuity (straight life) provides income payments for as long as the annuitant lives. Payments stop at death, regardless of how much has been paid out or how much remains in the account.

**139. A**

A period certain annuity guarantees payments for a specified number of years. If the annuitant dies before the period ends, payments continue to a beneficiary until the period is complete.

**140. B**

Twisting is an illegal practice where an agent misrepresents or makes misleading comparisons to induce a policyholder to cancel an existing policy and purchase a new one, often for the agent's commission benefit.

**141. C**

Churning is the unethical and often illegal practice of an agent inducing excessive policy replacements primarily to generate commissions, rather than for the client's benefit.

**142. D**

Rebating is the illegal practice of returning part of the premium or agent's commission to the policyholder as an inducement to purchase insurance. This is prohibited in most states.

**143. A**

Misrepresentation is making false, deceptive, or misleading statements, either oral or written, to induce someone to purchase, lapse, or change an insurance policy. This is illegal and unethical.

**144. D**

A paid-up policy is one for which no more premium payments are required, but the policy remains in force with its death benefit intact. This can result from using dividends or cash value to pay premiums.

**145. A**

The reduced paid-up option allows the policyholder to use the cash value to purchase a smaller permanent life insurance policy with no future premium payments required.

**146. B**

Extended term is a nonforfeiture option that uses the policy's cash value to purchase term insurance for the original face amount for as long as the cash value will allow.

**147. C**

Group life insurance covers multiple individuals under a single master policy, typically provided by employers. It usually offers term coverage and may be convertible to individual policies upon leaving the group.

**148. D**

Key person (key man) life insurance is purchased by a business on the life of a key employee, with the business as beneficiary. It protects the business against financial loss if that person dies.

**149. A**

A buy-sell agreement is a legally binding contract, often funded by life insurance, that allows surviving business owners to purchase a deceased owner's share of the business at a predetermined price.

**150. B**

Split-dollar life insurance is an arrangement where the premium costs and policy benefits are shared between an employer and employee (or other parties) according to a specified agreement.

**151. C**

Universal life policies deduct monthly charges (cost of insurance and expenses) from cash value. The waiver of monthly deductions rider pays those internal charges while the insured is totally disabled, so coverage continues - but it does not pay the full planned premium, so cash value growth may stall. A traditional waiver of premium rider on a whole life policy, by contrast, waives the entire premium.

**152. A**

A spendthrift clause protects proceeds the insurer still holds under a settlement option: the beneficiary cannot assign or borrow against future installments, and the beneficiary's creditors generally cannot reach payments before they are made. It does not police how money is spent once received, and it has no effect on a lump sum already paid out.

**153. B**

The insuring clause (or insuring agreement), usually on the policy's first page, states the insurer's core promise: to pay the stated death benefit to the named beneficiary on proof of the insured's death, subject to the policy's terms. The consideration clause instead describes what the policyowner gives in exchange - the application statements and the premium.

**154. B**

Representations are statements the applicant believes true to the best of their knowledge. Unlike warranties - which must be literally true - an inaccurate representation lets the insurer void coverage only if the misstatement was material to accepting the risk, and generally only during the contestable period.

**155. A**

Paid-up additions are small amounts of single-premium whole life insurance purchased with policy dividends. They increase the policy's death benefit and cash value without additional out-of-pocket premiums.

**156. A**

When the insured and primary beneficiary die together with no proof of survivorship, the Uniform Simultaneous Death Act directs proceeds to be paid as if the beneficiary died first - so they go to any contingent beneficiary, or to the insured's estate if none is named. Many policies add a common disaster (survivorship) clause requiring the beneficiary to outlive the

insured by a stated period, such as 30 days, to the same effect.

**157. C**

Coverage stays in force throughout the grace period, so a death during that time is covered. The insurer deducts the unpaid premium (and under some policies, interest on it) from the death benefit before paying the beneficiary. The claim is not denied, and the premium is not simply forgiven.

**158. D**

An other-insured rider - often called a spouse or family rider - attaches term coverage for someone besides the base insured, most commonly a spouse, to an existing policy. It is usually cheaper and simpler than a separate policy, though the added coverage is term insurance that ends when the rider period expires or the base policy terminates.

**159. A**

A family income rider is decreasing term insurance that pays monthly income from the insured's death until the END of the period selected, measured from the rider's start date - here, the remaining 10 of 20 years. A family maintenance rider, by contrast, pays income for a full period measured from the date of death. If the insured outlives the rider period, no income benefit remains.

**160. B**

The cost of insurance (COI) is the mortality charge deducted monthly from the policy's cash value to pay for the death benefit protection. It increases as the insured ages.

**161. C**

The corridor test is an IRS requirement that the death benefit must exceed cash value by a minimum percentage that varies by age. This ensures the policy qualifies as life insurance for tax purposes.

**162. D**

Table rating is a method of classifying substandard risks where each 'table' or 'letter' represents a percentage increase in mortality risk and premium. Higher tables mean greater risk and higher premiums.

**163. A**

A flat extra premium is an additional fixed dollar amount added to the standard premium to cover specific hazards, often for a limited period. It's commonly used for occupational or avocational risks.

**164. B**

Key person coverage protects the business, so the amount reflects the employee's economic value to the firm: profits that would be lost, the cost of recruiting and training a replacement, and credit or project commitments that depend on that person. The employee's personal finances are irrelevant - those belong to personal, not business, insurance planning.

**165. C**

With a single owner there are no partners for a cross-purchase and no entity to redeem shares, so the sale runs one way: the designated buyer owns and pays for a policy on the proprietor and uses the death benefit to purchase the business at the agreement's price. This lets the business continue rather than being liquidated with the estate.

**166. D**

In a cross-purchase plan, each business owner buys life insurance policies on the lives of the other owners. Upon an owner's death, the surviving owners use the death benefits to purchase the deceased's share.

**167. A**

In an entity purchase (or stock redemption) plan, the business purchases life insurance on each owner. Upon an owner's death, the business uses the death benefit to buy the deceased's ownership interest.

**168. B**

Split-dollar plans are structured two main ways. Under the endorsement method the employer owns the policy, pays most or all of the premium, and endorses the death benefit above its own interest to the employee's beneficiary. Under the collateral assignment (loan) method ownership is reversed: the employee owns the policy and assigns it to the employer as security for the premiums advanced.

**169. A**

Dependent life coverage adds modest death benefits on an employee's spouse and eligible children to a group life plan, with the employee normally the beneficiary. Benefit amounts are typically small - sized for final expenses - and are often limited relative to the employee's own coverage amount.

**170. D**

Contributory group insurance is a plan where employees pay part of the premium, typically through payroll deduction. This contrasts with noncontributory plans where the employer pays the entire premium.

**171. D**

Whole life insurance is permanent coverage. It is designed to remain in force for the insured's lifetime as long as required premiums are paid.

**172. A**

Term life insurance provides temporary protection for a selected term. It generally has no cash value feature.

**173. B**

Universal life insurance is known for premium flexibility and adjustable death-benefit features, subject to policy rules and sufficient policy values.

**174. C**

Decreasing term life provides a death benefit that declines over the policy period. It is often used for needs that shrink over time.

**175. C**

Single-premium whole life is bought with one payment and needs no further premiums, and substantial cash value exists immediately. Because one premium far exceeds the seven-pay test limit, such policies issued since 1988 are generally modified endowment contracts (MECs): lifetime withdrawals and loans are taxed earnings-first and may face a 10% penalty before age 59 1/2, though the income-tax-free death benefit is preserved.

**176. A**

Straight whole life is designed for lifetime coverage with level premiums and guaranteed cash value accumulation under the policy contract.

**177. B**

A joint life policy covers two or more insureds and commonly pays when the first insured dies. Survivorship life usually pays after the second death.

**178. C**

Survivorship life, also called second-to-die life, generally pays after the last surviving insured dies.

**179. D**

Credit life is designed to pay off or reduce a borrower's covered debt if the insured borrower dies.

**180. A**

Adjustable life allows certain changes, such as premium amount, face amount, or protection period, within insurer and policy guidelines.

**181. B**

The grace period gives the policyowner limited extra time to pay a premium while coverage usually remains in force.

**182. C**

The reinstatement provision may allow a lapsed policy to be restored if the policyowner meets the insurer's conditions, such as proof of insurability and payment of overdue amounts.

**183. D**

The entire contract is generally made up of the policy and the attached application, limiting what can be used as part of the contract.

**184. A**

After the contestable period ends, the insurer is generally limited in its ability to challenge the policy, except for issues allowed by law or policy terms.

**185. B**

The misstatement of age provision commonly adjusts benefits to match what the paid premium would have purchased at the insured's correct age.

**186. C**

Extended term insurance uses available cash value to keep the full face amount in force as term coverage for a limited time.

**187. D**

Reduced paid-up insurance uses cash value to buy a smaller amount of fully paid permanent insurance.

**188. A**

The free-look period gives the policyowner time to review the policy after delivery and cancel for a refund according to applicable rules.

**189. B**

An automatic premium loan provision can use available cash value to pay premiums and keep the policy in force, if the provision is included and conditions are met.

**190. C**

The fixed-period settlement option pays proceeds over a specified period. Payments stop when the selected period is complete.

**191. D**

The beneficiary is the person or entity designated to receive policy proceeds when the insured dies.

**192. A**

A revocable beneficiary can usually be changed by the policyowner. An irrevocable beneficiary generally has rights that require consent for certain changes.

**193. B**

A contingent beneficiary is next in line to receive proceeds if the primary beneficiary dies before the insured or cannot receive the benefit.

**194. C**

Per stirpes wording generally allows a deceased beneficiary's share to pass down to that beneficiary's descendants.

**195. D**

The policyowner generally controls ownership rights, including changing a revocable beneficiary, subject to policy rules.

**196. A**

An assignment transfers policy ownership rights, either fully or partially, to another party, depending on the assignment type.

**197. B**

A collateral assignment gives a creditor limited rights in the policy as security for a debt. Rights usually end when the debt is satisfied.

**198. C**

The policyowner owns the contract and generally controls rights such as changing beneficiaries, assigning the policy, and selecting options.

**199. D**

A rider is an added policy provision that changes, limits, or adds benefits to the base policy.

**200. A**

A waiver of premium rider can waive required premiums during a qualifying disability, subject to policy definitions and waiting periods.

**201. B**

A guaranteed insurability rider lets the insured buy additional coverage at certain option dates or events without proving insurability again.

**202. C**

An accidental death benefit rider pays an extra amount if death results from a covered accident and rider conditions are satisfied.

**203. D**

An accelerated death benefit rider may allow early access to a portion of the death benefit when the insured meets the rider's qualifying condition, such as terminal illness.

**204. A**

A payor benefit rider can waive premiums on a juvenile policy if the adult responsible for paying premiums dies or becomes disabled, as defined by the rider.

**205. B**

A term rider adds temporary life insurance coverage to the base permanent policy, often for a specific person or time period.

**206. C**

A cost-of-living rider can increase coverage based on an inflation measure or policy formula, helping reduce the effect of rising costs.

**207. D**

Underwriting is the insurer's risk-evaluation process. It helps determine whether to issue coverage and at what premium classification.

**208. A**

Life underwriting commonly considers application answers, health history, medical information, lifestyle factors, and other allowed risk information.

**209. B**

Insurable interest means the policyowner must have a recognized interest in the insured's continued life when the policy is issued.

**210. C**

Life insurance generally requires insurable interest at policy inception. A purely speculative policy on a stranger's life conflicts with that requirement.

**211. D**

The premium is the payment charged by the insurer for coverage under the policy.

**212. A**

A preferred risk classification is generally used for applicants who meet favorable underwriting standards and may qualify for lower premiums.

**213. B**

Substandard applicants present higher-than-standard risk and may be rated, charged an extra premium, or declined depending on underwriting guidelines.

**214. C**

Accurate application information is essential because the insurer relies on it for underwriting. Unauthorized changes can create serious compliance and validity issues.

**215. D**

An annuity is primarily designed to accumulate funds and/or provide income, often for retirement planning.

**216. A**

The accumulation period is the time when money is paid into the annuity and value builds before the payout phase begins.

**217. B**

During annuitization, the annuity value is converted into scheduled income payments according to the selected payout option.

**218. C**

A life-only option usually pays the highest lifetime income because payments stop at the annuitant's death and no refund or survivor payment is guaranteed.

**219. D**

A surrender charge is a contractual charge that may apply if the owner withdraws money or surrenders the annuity during the surrender period.

**220. A**

An immediate annuity is designed to start income payments soon after it is purchased. A deferred annuity delays payouts until a later date.

**221. B**

Life insurance death benefits are generally received income tax-free when paid as a lump sum to a named beneficiary. Interest paid with the proceeds may be taxable.

**222. C**

The death benefit itself is generally income tax-free, but interest credited while proceeds are held by the insurer is generally taxable as interest income.

**223. D**

Cash value in a permanent life policy generally grows tax-deferred while it remains inside the contract, subject to tax rules and policy treatment.

**224. A**

Withdrawals up to basis are generally a return of premium, but amounts above basis may be taxable. Candidates should remember tax treatment can vary by product and transaction.

**225. B**

Policy loans are generally not taxable when taken if the policy stays in force, but unpaid loans can reduce benefits and may create tax issues if the policy lapses or is surrendered.

**226. C**

Individual life insurance premiums are generally not deductible as a personal expense. Business and employee benefit situations may have separate rules.

**227. D**

When a policy is surrendered, any amount received above the policyowner's cost basis is generally taxable as ordinary income.

**228. A**

Qualified annuities are connected to retirement-plan rules and may receive special tax treatment. Taxes usually apply when distributions are taken, depending on the arrangement.

**229. B**

A MEC is a life insurance contract that fails certain funding tests. Distributions from a MEC can be taxed less favorably than distributions from a non-MEC policy.

**230. C**

For estate-tax concepts, ownership and incidents of ownership are important. Exam candidates should know that tax results depend on policy ownership and applicable law.

**231. D**

Group life insurance is commonly issued as a master policy to an employer or other eligible group sponsor, with certificates provided to covered members.

**232. A**

The employer or sponsor holds the master policy. Covered employees generally receive certificates explaining their coverage.

**233. B**

Group underwriting evaluates the group characteristics, participation, eligibility, and overall risk rather than fully underwriting each person in the same way as individual coverage.

**234. C**

In a contributory plan, employees or members contribute toward the premium. Participation requirements often help prevent adverse selection.

**235. D**

In a noncontributory group plan, the employer or sponsor pays the premium. These plans often require all eligible members to be covered.

**236. A**

A conversion privilege allows eligible individuals who lose group coverage to convert to an individual policy, often without evidence of insurability, within a limited time.

**237. B**

Eligibility rules help define the covered class and support fair administration. They also reduce the chance that only high-risk individuals join.

**238. C**

Group life benefits often use a schedule such as a flat amount, a multiple of salary, or a class-based amount to avoid unfair discrimination.

**239. D**

Group life coverage can provide convenient basic protection, often with employer support and simplified enrollment compared with individual underwriting.

**240. A**

Participation and eligibility rules help prevent adverse selection, where people most likely to need coverage are disproportionately the ones who enroll.

**241. B**

Life insurance can fund a buy-sell agreement by providing money to purchase a deceased owner's business interest according to the agreement.

**242. C**

Key person insurance helps a business manage the financial impact of losing a person whose skills, relationships, or leadership are important to operations.

**243. D**

In a key person arrangement, the business commonly owns the policy, pays the premium, and receives the proceeds if the key person dies.

**244. A**

In a cross-purchase plan, each owner typically owns a policy on the other owner or owners, providing funds to buy the deceased owner's interest.

**245. B**

In an entity-purchase arrangement, the business is commonly the policyowner and uses proceeds to redeem or purchase the deceased owner's interest.

**246. C**

An executive bonus arrangement uses life insurance as part of compensation for selected employees or executives, subject to tax and employment rules.

**247. D**

Business continuation planning uses life insurance to create liquidity when a death could disrupt ownership, operations, or financial stability.

**248. A**

A business must have a legitimate financial interest in the insured person's continued life, especially for key person or business-continuation coverage.

**249. B**

Key person coverage is appropriate when the death of a founder, owner, executive, or specialized employee could create financial loss for the business.

**250. C**

The buy-sell agreement sets the rules for transfer and valuation. Life insurance is often used to fund the obligations created by that agreement.

**251. D**

Settlement options describe ways policy proceeds can be paid, such as lump sum, interest only, fixed period, fixed amount, or life income options.

**252. A**

With an interest-only option, the insurer holds the principal proceeds for a period and pays interest according to the settlement arrangement.

**253. B**

The fixed-period option pays proceeds over a stated number of years. Payment size depends on the amount, interest, and selected period.

**254. C**

Under a fixed-amount option, the beneficiary receives a chosen dollar amount periodically until the proceeds and interest are exhausted.

**255. D**

A life income option provides payments based on the lifetime of the payee, with variations that may include period-certain or refund features.

**256. A**

Nonforfeiture options help the policyowner use accumulated cash value if a permanent life policy lapses or is surrendered.

**257. B**

Cash surrender allows the policyowner to receive the available cash value, less any charges or loans, and terminate the policy.

**258. C**

Reduced paid-up insurance uses available cash value as a single premium to purchase a smaller permanent policy with no further premium payments required.

**259. D**

Extended term insurance uses cash value to buy term coverage, usually for the original face amount, for as long as the cash value will support.

**260. A**

Cash surrender ends the policy and pays the available cash value. Reduced paid-up and extended term continue some form of coverage.

**261. B**

Replacement rules help ensure consumers understand the consequences of replacing existing coverage, including surrender charges, new contestability periods, and loss of benefits.

**262. C**

A replacement recommendation should fairly explain material disadvantages and advantages. Omitting important consequences can make the recommendation misleading.

**263. D**

Twisting is commonly used to describe misleading or deceptive conduct that induces a policyowner to replace or change coverage improperly.

**264. A**

Rebating generally involves offering something of value not specified in the policy as an inducement to buy insurance, where prohibited by law.

**265. B**

Producers should present coverage, limitations, costs, and suitability factors honestly so applicants can make informed decisions.

**266. C**

A replacement may create a new contestability period under the new policy. This is an important consumer consideration before replacing coverage.

**267. D**

A fair replacement discussion compares benefits, costs, limitations, charges, and underwriting consequences before the client makes a decision.

**268. A**

Overbroad guarantees and statements that hide costs, risks, or limitations are red flags. Producers must not misrepresent policy benefits or terms.

**269. B**

Consumer disclosure materials such as a buyer's guide or policy summary help applicants understand and compare life insurance features, costs, and limitations.

**270. C**

Good documentation supports compliance and helps show the basis for recommendations, disclosures, and client decisions.

**271. C**

Roth IRA contributions are always made with money that has already been taxed, so no current deduction is allowed; the payoff comes later when qualified distributions are received income-tax free. Deductibility is a traditional IRA concept, which is why the options referencing full or plan-conditioned deductions are wrong. IRA contributions never affect Social Security wage calculations.

**272. D**

Distributions taken before age 59 1/2 without a qualifying exception are subject to a 10 percent additional tax on top of regular income tax. The 6 percent figure is the annual excise tax on excess contributions left in an account. The 25 percent rate applies to SIMPLE IRA distributions taken within the first two years of participation. The 20 percent figure is the mandatory federal withholding on an eligible rollover distribution paid from an employer plan to the participant, which is

a withholding requirement rather than a penalty.

**273. A**

A signature feature of the Roth IRA is that the original owner never has to begin lifetime required minimum distributions, so the account can keep compounding untouched. Deductibility runs the other way: traditional IRA contributions may be deductible while Roth contributions never are. Both IRA types let earnings accumulate without current taxation, so that does not separate them, and there is no rule forcing a Roth owner to start distributions at an earlier age.

**274. B**

Section 403(b) arrangements are limited by statute to public education employers and tax-exempt charitable organizations described in 501(c)(3), such as hospitals and religious institutions. Ordinary for-profit employers use 401(k) plans instead, and federal civilian workers and uniformed service members use the Thrift Savings Plan. Self-employed individuals and partnerships would look to a SEP, SIMPLE, or Keogh (HR-10) arrangement.

**275. C**

A SEP is an employer-funded arrangement in which the employer deposits contributions directly into a separate IRA owned by each eligible worker, which is what makes it simple to administer. Salary reduction by employees is the hallmark of 401(k) and SIMPLE plans, not a standard SEP. The employer never owns the assets, and contributions are pre-tax rather than after-tax.

**276. D**

Congress designed the SIMPLE plan for smaller businesses, and eligibility is capped at employers with roughly 100 or fewer eligible employees. There is no rule requiring exactly 50 workers, and large employers with hundreds of workers must use a conventional 401(k) or pension arrangement. The absence of any size limit would defeat the purpose of a plan built specifically for small firms.

**277. A**

When an eligible rollover distribution is paid to the participant rather than transferred trustee to trustee, the plan is required to withhold 20 percent for federal income tax, and the participant must replace that amount out of pocket to roll over the full balance. A direct rollover avoids this withholding entirely, so the option claiming no withholding describes the wrong method. The money remains rollover-eligible, and the 10 percent early-distribution penalty, when it applies at all, is assessed on the tax return rather than withheld by the plan.

**278. B**

A qualified plan earns the employer an immediate deduction because the arrangement satisfies IRS participation and nondiscrimination standards, whereas a nonqualified plan usually delays the employer's deduction until the benefit is actually included in the employee's income. Nonqualified plans are attractive precisely because they may discriminate in favor of selected executives, so the option about stricter rules is reversed. Earnings in both plan types grow tax deferred, and qualified plan distributions are taxed as ordinary income rather than received tax free.

**279. C**

Pre-tax 401(k) deferrals reduce the employee's reportable wages now, and the money plus its earnings is taxed as ordinary income when withdrawn in retirement. The option describing income now and tax-free distributions later describes a designated Roth account instead. Deferrals are handled through payroll, not itemized deductions, and because the deferrals were never taxed going in, the entire distribution, not just the earnings, is taxable coming out.

**280. D**

Once required minimum distributions begin, any amount the owner fails to withdraw is subject to an additional excise tax on the shortfall, which is why the schedule must be tracked carefully. Naming a spouse as beneficiary does not eliminate the owner's own lifetime distribution requirement. The required beginning date is tied to the statutory starting age in the owner's early seventies, not to age 59 1/2, and the still-working exception applies to certain employer plans, never to a traditional IRA.

**281. A**

Implied authority covers the customary acts a producer must perform to carry out the duties that were expressly granted, even when the contract does not spell them out. Express authority refers only to powers written into the agreement. Apparent authority arises from the impression the insurer creates in the public's mind, and fiduciary duty describes how premium money must be handled rather than a category of agency authority.

**282. B**

Apparent authority exists when the principal's own conduct leads a reasonable third party to believe the agent is still authorized, and the insurer may be held to the resulting transaction. Express and implied authority both require an actual, existing agency relationship, which ended at termination. Concealment involves an applicant withholding a material fact, an unrelated issue.

**283. C**

An aleatory contract is one in which the values traded are deliberately lopsided and hinge on chance, since a small premium may produce a large death benefit or no benefit at all. The description of only one enforceable promise defines a unilateral contract, and the take-it-or-leave-it wording defines a contract of adhesion. Requiring conditions to be satisfied describes the conditional nature of the contract.

**284. D**

Because the insurer drafts the entire document and the applicant simply accepts or rejects it, courts treat the policy as a contract of adhesion and resolve unclear wording against the drafting party. Aleatory refers to the unequal exchange of value, unilateral to the fact that only the insurer makes an enforceable promise, and conditional to the requirement that duties be performed before benefits are paid. None of those three explains the rule of interpretation.

**285. A**

Modern life insurance treats applicant statements as representations, meaning they must be substantially true to the best of the applicant's knowledge, and only a material misrepresentation gives the insurer grounds to contest. Warranties demand literal exactness and are typically used in other contexts such as certain commercial or marine coverages. Because they are representations, an innocent immaterial error does not automatically void coverage.

**286. B**

Concealment is the intentional withholding of a material fact that the insurer needs in order to evaluate the risk, and it can support rescission during the contestable period. Waiver is the voluntary surrender of a known right by the insurer, and estoppel prevents a party from reversing a position that another party relied upon. Subrogation is a property and casualty recovery concept and has essentially no role in life insurance.

**287. C**

Estoppel prevents a party from asserting a right it has consistently appeared to give up when the other party reasonably relied on that conduct to its detriment. Adverse selection describes the tendency of poorer risks to seek coverage, and indemnity is the principle of restoring a loss without profit. Insurable interest concerns the relationship required at policy inception and has nothing to do with premium acceptance patterns.

**288. D**

Business partners have a genuine financial stake in one another's continued life, particularly when a buy-sell agreement funds the purchase of a deceased owner's interest, so insurable interest clearly exists. Mere proximity as a neighbor creates no financial dependence. Insuring a stranger for speculative gain is exactly the wagering arrangement the doctrine exists to prevent, and a charity needs an actual relationship and consent.

**289. A**

Utmost good faith imposes a mutual duty: the applicant must disclose material information about the risk and the insurer must deal fairly and describe the coverage accurately. The duty is not one-sided, so the options placing the obligation on only one party are incomplete. Honesty does not obligate an insurer to pay claims that fall outside the policy terms.

**290. B**

Adverse selection is the tendency for those most likely to have a claim to be the most eager to buy coverage, and underwriting screens exist to keep that imbalance from distorting the risk pool. The law of large numbers actually helps insurers by making aggregate losses more predictable as the pool grows. Indemnity concerns restoring a loss without allowing a profit, and reciprocity is the arrangement under which states honor one another's resident producer licenses when issuing a nonresident license.

**291. C**

The law of large numbers states that predictions become more reliable as the pool of similar, independent exposures increases, which is what lets actuaries set adequate premiums. It says nothing about any single insured's experience and does not remove the need to hold reserves for future claims. Rating still varies by risk classification, so uniform pricing is not a consequence of the principle.

**292. D**

A life policy pays the agreed face amount because the value of a human life cannot be measured precisely, making it a valued contract rather than one that reimburses proven loss. Property insurance follows indemnity and asks for proof of actual loss, which is why the receipt and economic loss choices do not fit. Benefits are not capped at funeral costs; the face amount controls.

**293. A**

Section 1035 permits a life policy to be exchanged for an annuity, a life policy for another life policy, or an annuity for another annuity, all without current recognition of gain. The reverse direction, annuity to life insurance, is specifically not permitted because it would convert taxable gain into a tax-free death benefit. Stocks and bank deposits are not insurance contracts and fall entirely outside the provision.

**294. B**

The seven-pay test compares cumulative premiums paid in the first seven years to what would have been required to pay the contract up in seven level annual payments; exceeding that limit creates a MEC. Age of the insured, riders attached, and the size of the face amount have no bearing on the classification. Once a contract fails the test it generally remains a MEC permanently.

**295. C**

MEC status flips the ordering rule so that gain is deemed withdrawn before basis, making the distribution taxable to the extent of earnings, and a 10 percent penalty may also apply before age 59 1/2. Ordinary non-MEC life insurance keeps the favorable first-in, first-out treatment. Gains from these contracts are taxed as ordinary income, not at capital gains rates, and the death benefit rather than living distributions is what remains income-tax free.

**296. D**

The exclusion ratio divides the investment in the contract by the expected total return, and the resulting percentage of each annuity payment is excluded from income as a recovery of principal. The remaining portion of each payment is taxable as ordinary income. Surrender-charge-free withdrawal amounts, tax withholding, and guaranteed rates are contract or administrative features unrelated to this tax calculation.

**297. A**

Death proceeds themselves are received income-tax free, but any earnings the insurer credits after the insured's death are ordinary interest income to the beneficiary. Treating the principal as taxable misstates the general rule for death benefits. Treating the interest as tax free would let the beneficiary earn investment income permanently without tax, which the Code does not allow.

**298. B**

Borrowing against a non-MEC life policy is treated as a loan rather than a distribution, so no income is recognized while the contract stays in force. If the policy later lapses or is surrendered with a loan outstanding, gain above basis can become taxable at that point. MEC loans are treated differently and are taxable to the extent of gain.

**299. C**

Policy dividends are considered a refund of premium the policyowner overpaid, so they are not income when received, although they do reduce the owner's cost basis. Interest credited on dividends left to accumulate with the insurer is a separate item and is taxable. The tax result does not change based on whether the dividend is taken in cash or applied to another dividend option.

**300. D**

On surrender, the owner recovers cost basis tax free and reports the excess of cash value over basis as ordinary income, here $15,000. Taxing the entire cash value ignores the return of the owner's own premium dollars. The income-tax exclusion applies to death benefits rather than living surrenders, and gain inside a life contract is ordinary income rather than capital gain.

**301. A**

The Code lists specific safe-harbor transferees, including the insured, a partner of the insured, a partnership in which the insured is a partner, and a corporation in which the insured is a shareholder or officer, and transfers to them keep the death benefit fully excludable. When a policy is sold for valuable consideration to anyone outside those exceptions, the beneficiary may exclude only the consideration paid plus subsequent premiums, and the balance becomes taxable. Investors, friends, and unrelated businesses do not fall within the exceptions.

**302. B**

Inside buildup in a life policy is not currently taxable, so the owner receives no annual tax reporting on the growth. Requiring annual reporting would eliminate one of the main advantages of permanent coverage. Capital gains rates never apply to life policy inside buildup, and self-employment tax applies to earned business income, not policy values.

**303. C**

Employer-paid group term life is excluded from the employee's income only up to $50,000 of coverage, and the cost of the excess amount, computed from a government table, is reported as imputed income. Taxing the entire premium ignores the statutory exclusion, and excluding all of it ignores the $50,000 ceiling. Employees cannot deduct life insurance premiums personally.

**304. D**

Nonqualified annuities follow a last-in, first-out rule during the accumulation phase, so withdrawals are deemed to come from taxable earnings before any basis is recovered, and a 10 percent penalty may apply before age 59 1/2. Principal-first treatment applies to non-MEC life insurance, not deferred annuities. Annuity gains are ordinary income and never receive capital gains rates.

**305. B**

Option A keeps the total death benefit level, so as the cash value builds the insurer's net amount at risk declines, which helps hold down mortality charges. Adding cash value on top of the face amount describes Option B, the increasing death benefit design. Because the total benefit is fixed, the net amount at risk falls rather than rises as cash value builds, and interest credited increases the cash value rather than the death benefit; the total payable to the beneficiary remains constant subject to corridor requirements.

**306. A**

A variable product is simultaneously an insurance contract and a security, so the producer needs the state life license plus FINRA registration through a broker-dealer. Holding only one credential leaves the producer unqualified for half the product; the securities registration belongs to the producer through a broker-dealer, not to the insurer, and federal registration does not preempt the state license. Investment adviser registration is a separate credential that does not authorize the sale of variable products.

**307. C**

Variable products place cash value in separate accounts made up of investment subaccounts, and the policyowner accepts the resulting gains and losses. General account placement with guaranteed minimums describes traditional whole life and fixed products. Life insurance values are not bank deposits and are not held by the state.

**308. D**

Indexed UL credits interest using a formula tied to an index such as a broad stock market benchmark, and the insurer limits both downside and upside through a guaranteed floor and a cap or participation rate. The policyowner never actually buys index shares. Because of caps and participation rates the credited rate rarely matches the raw index return, and daily net asset value pricing is a characteristic of variable products.

**309. A**

Survivorship life insures two lives and pays a single death benefit at the second death, which is exactly when estate settlement costs typically come due. Joint life pays at the first death, so the timing would be wrong. Separate policies pay at each individual death rather than a single coordinated benefit, and a family policy with riders simply covers each family member individually rather than paying at the second death.

**310. B**

An endowment is designed to build value quickly and pay the face amount either at the insured's death or upon reaching the maturity date, whichever comes first. Rapid cash value accumulation is central to the design, so an endowment builds value faster than ordinary whole life, not more slowly. Returning premiums alone at the end of a term describes return-of-premium term insurance, and the cash value is paid out at maturity rather than forfeited.

**311. C**

Credit life is written to retire a debt, so the lending institution is the beneficiary and may collect only up to the remaining balance owed. Paying the estate or the family would defeat the purpose of guaranteeing repayment to the lender. The lender cannot collect the full original loan amount, since insurable interest is limited to the balance still owed.

**312. D**

Modified premium designs help a buyer with strong future earning potential by charging less in the first few years and then stepping up to a higher level premium thereafter. Level premiums throughout describe ordinary whole life, and charging more in the early years reverses the design. Owner-selected premium amounts within limits describe universal life flexibility instead.

**313. A**

The whole point of a conversion privilege is that the insured may move to permanent coverage without proving good health, and the new premium is set using either attained age or original age depending on the option chosen. Requiring an exam or allowing denial for poor health would strip the provision of its value. Original age conversion exists but is not automatic, so saying the premium is always based on issue age is inaccurate.

**314. B**

A joint life contract covers two or more lives and pays a single benefit at the first death, which is useful for income replacement in a two-earner household or for a business partnership. Paying separately for each insured would require individual policies. Payment at the second death describes survivorship life, and there is no automatic age 65 termination.

**315. C**

Straight life pays the most per month because the insurer's obligation stops at the annuitant's death with no guarantee to anyone else. Adding a period certain, a refund feature, or a second life all impose extra obligations on the insurer and therefore reduce the monthly payment. The trade-off is that a straight life annuitant who dies early leaves nothing behind.

**316. D**

A period certain guarantees payments for the stated number of years, so the beneficiary collects for the balance of that term, which is four years here. Payments would stop at death only under a straight life option. The guarantee period does not restart at death, and returning payments already made describes a refund annuity rather than a period certain design.

**317. A**

A cash refund feature guarantees that at least the purchase amount comes back, paying any shortfall to the beneficiary as a single sum. If the same guarantee were paid out in continuing periodic payments, the option would be an installment refund annuity. The insurer retaining the balance describes straight life, and a refund feature does not extend payments for the beneficiary's own lifetime.

**318. B**

Joint and survivor options let the parties choose what percentage continues to the survivor, and a two-thirds election reduces the check to two-thirds of the joint amount but continues it for the survivor's lifetime. Stopping payments entirely would defeat the purpose of a survivor option. Reducing the check to one-third or continuing the full payment until the account runs out misstates the election, and the survivor's reduced payment continues for life rather than for a fixed period.

**319. C**

An immediate annuity is bought with a single premium and starts paying income right away, typically within one payment interval, whereas a deferred annuity holds and grows the money before any income begins. Single premium funding is actually required for an immediate annuity and is also available on deferred contracts. Both types can be issued in fixed or variable form, and the timing in the reversed option is backwards, since it is the deferred contract that waits before paying.

**320. D**

A fixed annuity places contract funds in the insurer's general account and promises a minimum guaranteed rate, so the insurer absorbs the investment risk. In a variable annuity that risk shifts to the contract owner, whose values move with the separate account subaccounts. Beneficiaries have no role during accumulation, and annuities carry no government guarantee.

**321. A**

Suitability standards require the producer to collect relevant consumer information such as age, income, liquidity needs, risk tolerance, and time horizon, and to have a reasonable basis for believing the recommendation fits. A client's expressed interest does not replace the required fact-finding, no attorney or accountant sign-off is required, and the consumer profile is retained by the producer and insurer rather than filed with the state for approval.

**322. B**

An indexed annuity credits interest based on movement in a named index while a floor protects against negative index years, and caps, spreads, or participation rates limit the upside. A minimum guarantee is a defining feature, so claiming there is none is wrong. Most indexed annuities are not registered securities, and like other annuities they can be annuitized for lifetime income.

**323. C**

The paid-up additions option buys tiny single-premium blocks of permanent insurance at the insured's attained age, and each addition carries its own cash value and can earn future dividends. Taking cash or applying the dividend against the next premium adds no new coverage. Leaving dividends to accumulate at interest builds a fund with the insurer but does not increase the death benefit through additional insurance.

**324. D**

The one-year term dividend option applies the dividend as a single premium for term coverage lasting one year, commonly limited to an amount tied to the policy's cash value. It does not prepay a future premium, which would simply be the premium reduction option, and it does not buy paid-up additions or shorten the premium-paying period; those are separate dividend options.

**325. A**

Dividends represent divisible surplus and vary with how favorably the insurer's actual mortality, expenses, and investment earnings compare to the assumptions used in pricing, so they can never be guaranteed. Illustrating them as guaranteed would be a misrepresentation. Dividends are treated as a return of excess premium rather than taxable earnings, and only participating policies pay dividends at all.

**326. B**

The dividend keeps its character as a return of overpaid premium and is not income, while any interest the insurer credits on the accumulated fund is reportable as ordinary income each year. Saying nothing is ever taxable overlooks that interest element. The dividend itself is not taxable when credited, and leaving funds with a life insurer does not exempt interest from tax.

**327. C**

A participating policy gives its owner a share in the insurer's divisible surplus through dividends, while a nonparticipating policy pays no dividends and typically carries a lower fixed premium. Cash value accumulation is a function of the policy design rather than dividend eligibility, and nonparticipating policies pay no dividends at all. Participating coverage is traditionally associated with mutual insurers, so the issuer pairing is reversed.

**328. D**

Fully insured status generally requires 40 quarters, or credits, of covered work, which equates to about ten years of employment and unlocks retirement and the broadest survivor benefits. The six-credits-in-13-quarters standard describes currently insured status, which provides a narrower set of survivor benefits. The 20 and 120 quarter figures are not the recognized thresholds for fully insured status.

**329. A**

The blackout period begins when the youngest eligible child reaches the age at which the caregiver benefit ends and lasts until the surviving spouse becomes eligible for widow or widower benefits, leaving a gap with no survivor income. This gap is a classic reason to recommend private life insurance. The other choices describe unrelated or reversed situations: early-claiming reductions, a frozen earnings record, and a caregiver benefit that is in fact paid while the youngest child is under 16 and ends, rather than begins, at that point.

**330. B**

Social Security survivor benefits are limited to defined family members, and an unmarried dependent child under 18, or under 19 if still in secondary school, is a primary eligible category. Siblings have no claim on a worker's earnings record, and a dependent parent qualifies only after reaching age 62. Business partners are not family members and receive nothing, which is why private life insurance is used for business continuation needs.

**331. B**

Under the increasing (Option B) arrangement, the beneficiary receives the specified amount plus the policy's cash value, so the total death benefit grows as the cash value grows: $300,000 + $40,000 = $340,000. Paying only the specified amount describes the level (Option A) design, and the cash value is never subtracted from or substituted for the face amount. State insurance department consumer guides describe the two universal life death benefit options exactly this way.

**332. C**

Under the cash value corridor of 26 U.S.C. 7702(d), the applicable percentage for an insured under age 40 is 250 percent, so the death benefit must be at least 250% x $100,000 = $250,000. The percentage grades down at older ages, reaching 105 percent in the late-70s-to-80s range and 100 percent by age 95. If the death benefit fell below the corridor, the contract would lose its tax status as life insurance. See 26 U.S.C. 7702.

**333. A**

Premium flexibility does not make universal life coverage free: every month the insurer keeps deducting cost-of-insurance and expense charges from the account value, and when the cash value can no longer cover them, the policy lapses. Oregon's insurance regulator warns that owners who underpay 'receive a notice from their insurance company that their policy will cancel if they do not increase their payment.' The policy did not lapse three years ago precisely because the cash value kept it in force, and extended term is a whole life nonforfeiture mechanism, not an automatic universal life feature.

**334. D**

Universal life policies credit a current interest rate declared by the insurer, but only the guaranteed minimum stated in the contract is promised for the life of the policy. The NAIC's buyer's guide notes that non-variable policies 'often have guaranteed minimums for some features (interest or cash value, for example),' while illustrated current rates are projections the insurer may lower. An illustration never converts a current rate into a guarantee.

**335. C**

A universal life account works like a bucket: premiums and credited interest flow in, and each month the insurer takes out the cost of insurance (the mortality charge for the death benefit) and the policy's expense charges. Oregon's insurance regulator describes it the same way: 'Money is taken out of the bucket by the cost of insurance and the expense charges of the policy.' Surrender charges apply only on early termination, and loan interest accrues only if a loan exists.

**336. B**

The target (or suggested) premium is the insurer's estimate of the level payment that would sustain the coverage - Oregon's regulator describes it as 'estimating what payment would provide coverage to age 100 without depleting the cash value.' Because insurers 'can only make educated predictions on future interest rates,' actual results can fall short, and owners may later be told to pay more to avoid lapse. It is neither a statutory amount, a contribution ceiling, nor a MEC threshold - the MEC limit under 26 U.S.C. 7702A is a separate calculation.

**337. A**

In variable and variable universal life, cash values are held in separate account subaccounts chosen by the policyowner, who therefore bears the investment risk. The NAIC's buyer's guide notes these policies 'have the greatest potential to build cash value but also the greatest risk of losing cash value,' while it is non-variable policies that carry guaranteed minimums. Neither the insurer's general account nor the fund managers make up separate account losses.

**338. D**

An indexed policy's floor sets the minimum interest credited regardless of index performance, so with a 0 percent floor a down year credits zero rather than a loss; the cap matters only in up years, limiting the maximum credited (an 8 percent loss never triggers the 10 percent cap). Regulators' investor guidance on indexed products explains that a floor 'places a lower limit' on loss exposure while a cap limits upside participation. The cash value is not invested directly in the index, so it does not mirror the decline.

**339. B**

Traditional whole life is the design in which 'both the death benefit and the premium are designed to stay the same (level) throughout the life of the policy,' with cash values that grow on a guaranteed schedule (iii.org; California DOI life insurance guide). Annual renewable term premiums increase at each renewal, universal life premiums and values depend on non-guaranteed current interest and charges, and variable universal life shifts investment risk to the owner.

**340. A**

Limited-payment whole life compresses the same lifetime funding into a set number of premiums - the NAIC glossary defines it as whole life 'with a pre-defined number of premiums to be paid.' Squeezing the funding into 20 years makes each premium higher and builds cash value faster, but the policy stays in force for life with the same face amount once paid up. Coverage does not end when premiums end; that confusion belongs to term insurance.

**341. C**

A single-premium policy is fully funded at issue, so it has significant cash value immediately - but paying the entire premium at once necessarily exceeds the 7-pay limit of 26 U.S.C. 7702A, making the contract a modified endowment contract. MEC status changes the tax treatment of lifetime loans and withdrawals; the death benefit still qualifies as life insurance. Any premium pattern, fixed or flexible, that outruns seven net level annual premiums triggers MEC status.

**342. D**

Modified (and the similar graded) premium whole life redistributes the premium: the owner pays less than a standard whole life premium for the first few years, then a somewhat higher level premium for the rest of the policy's life, which suits buyers whose incomes are expected to grow. Single-premium and 20-pay designs demand more money sooner, not less, and universal life is a different product rather than a whole life premium schedule.

**343. B**

A policy loan is an advance from the insurer secured by the cash value, and any balance still outstanding at death is deducted from the proceeds: $150,000 - $25,000 = $125,000. The California DOI guide notes cash value serves as 'loan collateral for borrowing funds at the interest rate specified in the policy.' Loans are never forgiven at death, and the beneficiary is not personally obligated to repay them.

**344. C**

The reduced paid-up option uses the existing cash value as a single premium to buy a smaller amount of fully paid permanent insurance, so some coverage continues for life with no further premiums - exactly Marcus's goal. Surrender ends the coverage in exchange for cash, extended term keeps the full face amount but only for a limited period, and borrowing then lapsing destroys the coverage. Nonforfeiture options exist so a policyowner who stops paying does not forfeit the value already built.

**345. A**

A nonparticipating policy pays no dividends; everything the owner will receive is fixed and guaranteed in the contract at issue. A participating policy, by contrast, shares in the insurer's divisible surplus through dividends - the NAIC glossary describes a dividend as 'a refund of a portion of the premium paid by the insured from insurer surplus.' Fixed guaranteed values with no surplus sharing is the defining mark of nonpar coverage.

**346. D**

A children's term rider provides level term coverage on all eligible children of the insured for one premium, and children born or adopted after issue are typically covered automatically once past a minimum age (such as 15 days), with no additional premium or underwriting. New York's insurance regulator notes a children's rider 'will generally provide level term coverage on the life of your children and is usually offered at one premium rate.' That one-premium, all-children design is what distinguishes it from buying separate juvenile policies.

**347. B**

New York's insurance regulator explains that a return of premium rider 'will generally provide for a refund of all or some of the premiums you paid for the term insurance at the end of a level term period... if no death benefit was paid out during that period.' The rider costs extra and pays the insured for outliving the term; it does not convert the policy to paid-up whole life or pay the face amount to a living insured.

**348. C**

A long-term care rider lets the insured 'use part of your death benefit to pay for long-term care expenses,' and chronic illness triggers are based on inability to perform activities of daily living - not on a terminal diagnosis (NAIC consumer guidance). The basic accelerated death benefit for terminal illness requires a diagnosis with a limited life expectancy, which Gloria does not have. Waiver of premium excuses premiums during disability, and guaranteed insurability only permits buying more coverage.

**349. A**

A cost of living rider lets the policyowner purchase additional insurance periodically, with the amount 'based on increases in the cost of living index,' so the death benefit can keep pace with inflation (New York DFS consumer guidance on optional riders). The typical index is the Consumer Price Index. None of the other riders changes the amount of coverage in response to inflation.

**350. C**

The payor benefit rider is attached to juvenile policies and 'provides for waiving future premiums on the child's policy in the event of the death of the person who pays the premium' - most versions also apply if the payor becomes totally disabled - until the child reaches a stated age such as 21 or 25 (New York DFS consumer guidance). The insured child is alive, so no death benefit is payable, and the coverage continues rather than being canceled or converted.

**351. B**

Waiver of premium excuses premium payments during total disability so the coverage continues, but it puts no cash in the insured's pocket. The separate disability income rider 'provides a monthly income while you are totally disabled after an initial waiting period, with the monthly disability income benefit limited to a percentage of the death benefit' (New York DFS consumer guidance). Option C reverses the two riders' functions.

**352. A**

The guaranteed insurability (guaranteed purchase option) rider lets the insured 'increase your death benefit at certain times without a medical exam' - typically at stated ages or life events such as marriage or the birth of a child (NAIC consumer guidance; California DOI guide). Because insurability is locked in at issue, later health changes cannot block the additional purchases. The cost of living rider tracks an index rather than her life events, and the other riders do not add coverage at all.

**353. D**

The cash option simply has the insurer send the declared dividend to the policyowner as a check, giving Arthur spendable funds each year. Paid-up additions and one-year term convert the dividend into additional insurance, and accumulate at interest leaves the money on deposit with the insurer - none of those puts cash in his hands. Dividends are a return of the policyowner's share of divisible surplus (NAIC glossary).

**354. A**

Under the premium reduction (reduce premium) option, the dividend is credited directly against the next premium due, so Beth's out-of-pocket cost drops to $1,800 - $300 = $1,500. Receiving a separate check describes the cash option, and buying more coverage describes paid-up additions. A dividend rarely covers the whole premium, so a full waiver is not what the option promises.

**355. B**

Dividends accumulated at interest are the policyowner's money held on deposit with the insurer: they can be withdrawn at any time, and at the insured's death they are paid in addition to the face amount - here $100,000 + $18,000 = $118,000. The accumulation is never forfeited to the insurer or netted against the death benefit; unlike a policy loan, it is an asset, not a debt.

**356. C**

Under the paid-up additions option, each dividend is applied as a single premium buying a small, fully paid block of permanent insurance that raises both the death benefit and the cash value - and no medical underwriting is required, so declining health cannot stop the growth. The additions are real insurance priced at attained age, not a side fund, and no ten-year rule exists.

**357. D**

Because one-year term insurance is pure protection with no cash value, a dividend used as its single premium buys far more temporary death benefit than the same dollars would buy as paid-up permanent additions - though the extra

coverage lapses at the end of each year. Paid-up additions buy a smaller but permanent increase, while accumulation and premium reduction add no death protection at all.

**358. B**

IRS Publication 550 treats dividends on insurance policies as a partial return of the premiums paid, nontaxable so long as cumulative dividends do not exceed total premiums. Frank's $4,000 is far below his $60,000 premium outlay, so nothing is reportable. Dividends are never repayable at surrender; they simply reduce his cost basis in the policy.

**359. A**

The dividend itself is a nontaxable return of premium, but interest earned on dividends left on deposit with an insurance company is taxable in the year it is credited, per IRS Publication 550. So Iris reports the $120 of interest and nothing more. Leaving the money with the insurer does not shelter the interest the way cash value growth inside the policy is sheltered.

**360. C**

Dividends are a nontaxable return of premium only up to the policyowner's total premiums paid. Sylvia's cumulative dividends ($32,000) now exceed her premiums ($30,000) by $2,000, so that excess is taxable income; the first $1,000 of this year's dividend simply finished recovering her cost. IRS Publication 550 states dividends are nontaxable only 'to the extent they don't exceed the total premiums paid.'

**361. B**

A surviving spouse's benefit based on having a child in care generally ends when that child reaches age 16 (unless the child is disabled), even though the child's own benefit continues until 18. The spouse then collects nothing until age 60 at the earliest - the blackout period life insurance is often designed to bridge. See 42 U.S.C. 402.

**362. A**

Federal law provides a lump-sum death payment equal to three times the worker's primary insurance amount or $255, whichever is smaller, paid first to a widow or widower who was living in the same household as the deceased. Because of the $255 cap, the payment is at most $255. See 42 U.S.C. 402(i).

**363. D**

A worker with at least 6 quarters of coverage in the 13-quarter period ending with death is 'currently insured,' which preserves certain survivor benefits even without fully insured status. Forty quarters is one way to be fully insured for life, not a universal minimum, and a young worker can also be fully insured with fewer quarters (one per year elapsing after age 21). See 42 U.S.C. 414.

**364. B**

A child qualifies while under age 18, or under age 19 if a full-time elementary or secondary school student; a full-time high-school student who is 18 therefore still qualifies. College attendance does not extend benefits, and adult children qualify only if disabled before age 22. See 42 U.S.C. 402(d).

**365. C**

A needs analysis totals the survivors' income needs and then subtracts other post-death income sources; Social Security survivors' benefits are the most common such source, so the life insurance recommendation covers only the remaining shortfall. No law compels the deduction, and it has no effect on the policy's death benefit. See iii.org.

**366. A**

A widow or widower generally qualifies for survivor benefits at age 60, but one who is disabled may qualify after attaining age 50 and before 60. Without a disability or an entitled child in care, benefits are not payable at 52. See 42 U.S.C. 402(e).

**367. D**

Every guarantee added to a life-only payout is paid for with a smaller periodic payment. A joint and 100 percent survivor option must continue the full payment as long as either of two people is alive, the most expensive guarantee listed, so it pays the least; life only, with no guarantee to anyone after death, pays the most.

**368. C**

Systematic withdrawals leave the owner in control of the remaining value, though nothing guarantees the money will last for life. Annuitization works the other way: the owner gives up control of the investment to the insurer in exchange for a guaranteed income stream, and the decision is generally irrevocable. See finra.org.

**369. B**

The exclusion ratio is investment in the contract divided by expected return: $60,000 / $150,000 = 40 percent. So $400 of each $1,000 payment returns basis tax-free and $600 is taxable earnings, until the investment is fully recovered. See 26 U.S.C. 72(b).

**370. A**

Section 1035 permits tax-free exchanges of life insurance for life insurance, an endowment, an annuity, or qualified long-term care coverage, and an annuity for another annuity or long-term care contract - but not an annuity for life insurance. The rule runs one way only, and neither the insurer's identity nor a 60-day window changes that. See 26 U.S.C. 1035.

**371. C**

A qualified annuity funded entirely with pre-tax dollars has no cost basis, so every dollar distributed is ordinary income. A nonqualified annuity is bought with after-tax dollars, so each annuitized payment splits between a tax-free return of premium and taxable earnings under the exclusion ratio. See 26 U.S.C. 72 and finra.org.

**372. D**

Premature distributions from annuity contracts carry an additional tax of 10 percent of the amount includible in gross income. The penalty does not apply to distributions made on or after age 59 1/2, or under other listed exceptions such as death or disability. See 26 U.S.C. 72(q).

**373. A**

An MVA adjusts the value paid on early withdrawal to reflect interest rate changes: when rates are higher than at purchase, the MVA can reduce the amount taken; when rates are lower, it can increase it. This protects the insurer from having to liquidate bonds at depressed prices. The MVA applies to withdrawals and surrenders, not taxation.

**374. B**

A QLAC is an annuity purchased from an insurer under a 401(a), 403(a), 403(b), governmental 457(b) plan, or a non-Roth IRA; before annuitization its value is excluded from the account balance used to determine RMDs. Its distributions must begin no later than the first day of the month after the employee's 85th birthday. A Roth IRA contract is specifically not treated as a QLAC. See IRS Instructions for Form 1098-Q.

**375. C**

The human life value approach measures the economic value of the insured's future earnings to dependents - projected income less self-maintenance costs, discounted to present value. The needs approach instead totals the survivors' actual cash and income needs and subtracts existing resources such as savings and Social Security.

**376. A**

Risk pooling groups a large number of similar risks together, which spreads the risk and makes coverage affordable; with many insureds, the number of deaths becomes predictable and each member's share of the losses is small. Premiums are invested, but no single premium is expected to grow to the face amount, and legal reserve insurers do not levy after-death assessments.

**377. D**

Term insurance is pure death protection: it pays only if death occurs during the term and builds no cash value, which is why it delivers the most coverage per premium dollar. Whole life and the other permanent forms cost more at issue because part of each premium funds a lifetime guarantee and a savings element she does not want. See iii.org.

**378. B**

In life insurance, insurable interest must exist at the inception of the contract; it need not continue to the date of death. The partners had a genuine financial interest in each other's lives when the policy was issued, so the later dissolution does not defeat the claim. Business life insurance requires insurable interest at issue like any other policy.

**379. C**

Life policies must provide that the policy - or the policy together with the application if a copy is endorsed upon or attached to it at issue - constitutes the entire contract between the parties. Statements in an attached application are, absent fraud, deemed representations rather than warranties; an unattached application cannot be used against the insured. See, e.g., Va. Code 38.2-3304, reflecting the standard provision.

**380. A**

A conditional receipt specifies conditions - typically that the applicant prove insurable - that, once satisfied, make coverage effective as of the receipt (or exam) date even if the applicant dies before the policy is issued. Because underwriting found him a standard risk, the condition was met and the claim is payable. A binding receipt, by contrast, provides temporary coverage immediately regardless of insurability.

**381. B**

Only public educational institutions and 501(c)(3) tax-exempt organizations (plus certain ministers) may maintain 403(b) plans, so the public school teacher qualifies. Employees of for-profit companies and self-employed business owners must look to 401(k), SEP, SIMPLE, or IRA arrangements instead. See irs.gov.

**382. D**

A SIMPLE IRA plan is limited to employers with 100 or fewer employees that do not maintain any other retirement plan, and it requires either a 3 percent matching or 2 percent nonelective employer contribution. Because the firm already sponsors a 401(k), it is generally ineligible; the 100-employee figure is a maximum, not a minimum. See irs.gov.

**383. A**

Roth IRA contributions are never deductible, but qualified distributions - including the earnings - are received tax-free, and amounts can be left in the account for life. Traditional IRA and SEP dollars are taxed when withdrawn, and a nonqualified annuity's earnings are taxable at distribution. See irs.gov.

**384. C**

ERISA regulates most voluntarily established private-sector retirement and health plans - setting minimum standards for participation, vesting, benefit accrual, and funding, imposing fiduciary responsibilities, and giving participants the right to sue - but it does not compel any employer to create a plan. Government and church plans are actually among those exempt from ERISA. See dol.gov.

**385. D**

Rollover treatment does not apply to any transfer made after the 60th day following the day the distributee received the distribution. June 1 to August 20 is 80 days, so absent an IRS hardship waiver the amount is included in income. The tax year in which the deposit lands is irrelevant. See 26 U.S.C. 402(c)(3).

**386. B**

Life settlement transactions run through settlement companies or providers, and consumers are advised to confirm the buyer is properly licensed with the state insurance commissioner. Providers either keep policies until maturity or resell them to hedge funds and institutional investors. Surrendering to the insurer pays only cash value, not a negotiated settlement, and producers do not buy clients' policies personally. See finra.org.

**387. A**

A viatical settlement is the sale of a terminally ill person's life insurance policy to an investor at a discount from the death benefit, with the price reflecting the insured's life expectancy; ordinary life settlements, by contrast, typically involve older insureds who are not terminally ill. An accelerated death benefit comes from the insurer itself under a policy rider, not from a third-party purchaser.

**388. C**

A life settlement makes economic sense only because the price exceeds what the insurer would pay on surrender, while the investor profits by paying less than the net death benefit it will eventually collect. An offer below cash surrender value should simply be declined in favor of surrendering. Premiums paid are not the pricing benchmark. See finra.org.

**389. D**

Because the purchase price depends on life expectancy, settlement buyers evaluate the insured's health and may share that information with other entities including lenders or third-party investors, and investors have an ongoing interest in the insured's status. Consumers are urged to review how their information will be used before selling. See finra.org.

**390. B**

A life settlement transfers ownership of the policy: the buyer takes over premium payments, names itself beneficiary, and collects the death benefit when the insured dies. The original beneficiary's expectation ends at the sale - a consequence the seller should weigh, since the family receives only whatever remains of the settlement proceeds. See finra.org.

**391. B**

Simplified issue underwriting skips the medical exam but still asks health questions and screens the answers against sources such as MIB records and prescription-history databases. Because the insurer accepts more uncertainty than with a fully underwritten policy, coverage amounts are usually smaller and the premium per dollar of coverage is usually higher.

**392. A**

Guaranteed issue life insurance accepts every applicant in the eligible age band with no health questions and no exam. Since the insurer cannot screen out poor risks, these policies are sold in small face amounts (often marketed for final expenses), carry the highest premium per dollar of coverage, and nearly always include a graded death benefit for the first years.

**393. C**

Under a typical graded death benefit, death from natural causes during the graded period (commonly the first two or three policy years) pays a return of the premiums paid, often with interest, rather than the face amount. Accidental death is usually covered for the full face amount from the first day. After the graded period ends, natural death also pays the full benefit.

**394. D**

Accelerated underwriting uses data and predictive models to deliver a decision comparable to full underwriting without the exam for applicants who qualify. Unlike simplified issue, pricing can match fully underwritten rates - but applicants whose data raises questions can still be routed into traditional underwriting with an exam.

**395. A**

A paramedical exam is performed by a nurse or trained technician rather than a physician and typically includes a health questionnaire, basic measurements, and specimen collection. It differs from an attending physician statement, which is a report requested from a doctor who has treated the applicant, and from MIB checks, which query coded industry records.

**396. C**

Guaranteed issue exists for people who cannot pass underwriting: it offers small face amounts, the highest cost per dollar of coverage, and graded death benefits. A healthy applicant who can complete full underwriting will nearly always pay less per dollar of coverage for far more coverage. Steering an insurable client seeking $500,000 toward guaranteed issue would be unsuitable.

**397. B**

The primary purpose of health insurance is to pay for or reimburse medical expenses including hospitalization, doctor visits, medications, and other healthcare services.

**398. C**

A deductible is the amount the insured must pay out-of-pocket for covered healthcare services before the insurance company begins to pay. Higher deductibles generally mean lower premiums.

**399. D**

Coinsurance is the percentage of covered healthcare costs that the insured pays after the deductible has been met. For example, with 80/20 coinsurance, the insurer pays 80% and the insured pays 20%.

**400. A**

A copayment is a fixed dollar amount that the insured pays for a covered healthcare service at the time of service. For example, a $30 copay for a doctor visit or $10 copay for a generic prescription.

**401. B**

The out-of-pocket maximum is the most you'll pay during a policy period for covered services through deductibles, copays, and coinsurance. After reaching this limit, the insurance company pays 100% of covered expenses.

**402. C**

A pre-existing condition is generally a condition for which the insured received diagnosis, care, or treatment before the coverage began. For ACA-compliant individual and group major medical coverage, insurers may not deny coverage, exclude the condition, or charge more because of it. Excepted benefits such as disability income, long-term care, and hospital indemnity coverage may still underwrite and apply pre-existing condition limits, as may short-term limited-duration insurance, which is not treated as individual health insurance coverage.

**403. D**

A network is the group of doctors, hospitals, pharmacies, and other healthcare providers that have contracted with a health insurance plan to provide services at negotiated rates.

**404. A**

Prior authorization (also called pre-authorization) is approval from the insurance company required before the insured can get a specific service or medication. Without it, the insurer may not pay for the service.

**405. B**

An HMO is a type of managed care plan that requires members to use network providers, select a primary care physician (PCP), and get referrals from the PCP to see specialists.

**406. C**

A PPO offers more flexibility than an HMO. Members can see any provider but pay less when using in-network providers. Referrals are typically not required to see specialists.

**407. D**

An EPO is a hybrid plan that requires members to use network providers (like an HMO) but typically doesn't require referrals to see specialists (like a PPO). Out-of-network care is only covered in emergencies.

**408. A**

An HDHP has higher deductibles and lower monthly premiums than traditional plans. HDHPs can be paired with Health Savings Accounts (HSAs) for tax-advantaged savings for medical expenses.

**409. B**

A POS plan combines features of HMOs and PPOs. Members choose a primary care physician and need referrals for specialists, but can also go out-of-network for higher costs.

**410. C**

Major medical provides broad coverage for hospitalization, surgery, physician services, and related care. An ACA-compliant plan may not place annual or lifetime dollar limits on essential health benefits, so the ceiling a student should associate with it is the annual out-of-pocket maximum rather than a benefit maximum. It is not the same as basic medical expense coverage, a hospital indemnity policy, or a limited dread-disease policy.

**411. D**

An HSA is a tax-advantaged savings account for medical expenses available to individuals enrolled in a High Deductible Health Plan. Contributions are tax-deductible, growth is tax-free, and withdrawals for qualified medical expenses are tax-free.

**412. A**

An FSA is an employer-sponsored benefit that allows employees to set aside pre-tax dollars for medical expenses. Unlike HSAs, FSAs typically have 'use-it-or-lose-it' rules, though some carry-over is allowed.

**413. B**

The elimination period (also called waiting period) is the time between when a covered event occurs (like disability) and when benefits begin. Longer elimination periods result in lower premiums.

**414. C**

Coordination of benefits determines which insurance plan pays first (primary) and which pays second (secondary) when a person has coverage under more than one health plan, preventing duplicate payments.

**415. D**

The benefit period is the length of time during which benefits are provided for a covered event. For example, a hospital policy might have a 90-day benefit period per hospital stay.

**416. A**

A guaranteed renewable policy must be renewed by the insurer as long as premiums are paid, regardless of changes in the insured's health. However, the insurer may increase premiums for the entire class of policyholders.

**417. B**

A noncancellable policy cannot be cancelled by the insurer, and the insurer cannot raise premiums above what's stated in the policy, as long as premiums are paid on time. This provides maximum protection.

**418. C**

Subrogation is the insurer's right to recover money paid for claims from a third party who caused the insured's injury or illness. For example, if you're injured in a car accident caused by another driver.

**419. D**

Disability insurance provides income replacement when the insured cannot work due to a covered illness or injury. It helps maintain financial stability during periods of disability.

**420. A**

Own occupation disability means the insured is considered disabled if they cannot perform the duties of their specific occupation, even if they could work in another occupation.

**421. B**

Any occupation disability is a stricter definition where the insured is only considered disabled if they cannot perform the duties of any occupation for which they are reasonably suited by education, training, or experience.

**422. C**

Short-term disability insurance provides income replacement for a limited period, typically 3-6 months, during which the insured cannot work due to illness or injury.

**423. D**

Long-term disability insurance provides income replacement for extended periods, potentially lasting years or until the insured reaches age 65, after short-term disability benefits are exhausted.

**424. A**

Residual disability coverage provides partial benefits when the insured can return to work but at reduced hours or in a limited capacity, resulting in reduced income.

**425. B**

Medicare is a federal health insurance program primarily for people 65 and older, as well as certain younger people with disabilities and those with End-Stage Renal Disease.

**426. C**

Medicare Part A is hospital insurance that covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

**427. D**

Medicare Part B is medical insurance that covers physician services, outpatient care, preventive services, durable medical equipment, and some home health care.

**428. B**

Medicare Part C (Medicare Advantage) plans are offered by private insurers approved by Medicare. They must cover everything Original Medicare covers and often include additional benefits like vision, dental, and prescription drugs.

**429. A**

Medicare Part D provides prescription drug coverage. It's offered through private plans approved by Medicare, either as stand-alone prescription drug plans or as part of Medicare Advantage plans.

**430. C**

Medicare Supplement (Medigap) policies are sold by private insurers to help pay for out-of-pocket costs not covered by Original Medicare, such as deductibles, copays, and coinsurance.

**431. D**

Medicaid is a joint federal and state program that provides health coverage to eligible low-income individuals, families, children, pregnant women, elderly, and people with disabilities.

**432. A**

Yes, some individuals qualify for both Medicare and Medicaid. These 'dual eligible' beneficiaries get Medicare coverage plus Medicaid may pay their Medicare premiums and cover additional services.

**433. B**

Group health insurance is health coverage provided to a defined group of people, most commonly employees of a company, under a single master policy. Risk is spread across the group.

**434. C**

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows employees and their families to continue group health coverage for a limited time after qualifying events like job loss, reduced hours, or divorce.

**435. D**

COBRA coverage typically lasts 18 months for most qualifying events (job loss, reduced hours). It can extend to 36 months for certain events like divorce or a child losing dependent status.

**436. A**

Under COBRA, the person continuing coverage - typically the former employee - pays the full premium cost (including the portion the employer previously paid) plus up to a 2% administrative fee, which is often far more than the payroll share paid while employed. COBRA rights can also follow a reduction in hours or a dependent qualifying event such as divorce, so the continuing enrollee is not always someone who left the company.

**437. B**

COBRA applies to employers with 20 or more employees who offer group health plans. Smaller employers may be subject to state continuation laws (often called 'mini-COBRA').

**438. C**

The Affordable Care Act (also known as 'Obamacare') is a comprehensive federal law enacted in 2010 that reformed health insurance markets, expanded Medicaid, created health insurance marketplaces, and established consumer protections.

**439. D**

Essential health benefits are 10 categories of services that ACA marketplace plans must cover, including hospitalization, prescription drugs, maternity care, mental health services, preventive care, and pediatric services.

**440. A**

A health insurance marketplace (also called an exchange) is a platform, either state-run or federally-facilitated (HealthCare.gov), where individuals and families can shop for, compare, and purchase ACA-compliant health insurance plans.

**441. B**

Premium tax credits are subsidies available to individuals who purchase health insurance through the marketplace and have income within certain limits. They reduce monthly premium costs.

**442. C**

Guaranteed issue means the insurer must accept all applicants regardless of health status or pre-existing conditions during open enrollment or a qualifying special enrollment period. It governs acceptance, not price. Premiums may still vary by age, tobacco use, geographic area, and family size, but not by health status or gender.

**443. D**

The open enrollment period is the annual timeframe (typically in the fall) when individuals can enroll in new marketplace health plans or make changes to existing coverage. Outside this period, enrollment requires a qualifying life event.

**444. A**

A special enrollment period allows individuals to enroll in marketplace coverage outside the open enrollment period due to qualifying life events such as marriage, birth of a child, loss of other coverage, or moving.

**445. B**

HIPAA (Health Insurance Portability and Accountability Act) is a federal law that protects the privacy of health information and ensures portability of health coverage when changing jobs.

**446. C**

Unfair trade practices are illegal activities prohibited by state insurance regulations, including misrepresentation, false advertising, defamation, unfair discrimination, and rebating.

**447. D**

Unfair discrimination occurs when an insurer treats similarly situated individuals differently based on factors not related to risk, such as race, religion, or national origin, rather than legitimate underwriting factors.

**448. A**

A producer is expected to act honestly and recommend coverage that fits the client's needs, rather than steering the sale toward the highest commission or the most expensive product. In agency law the producer legally represents the insurer, and a binding legal best-interest standard applies only in specific contexts such as annuity suitability rules. The separate term fiduciary responsibility usually refers to holding premium funds in trust without commingling them.

**449. C**

A formulary is a list of prescription drugs covered by a health insurance plan. Drugs are often organized into tiers, with different cost-sharing amounts for each tier.

**450. D**

Step therapy requires patients to try one or more lower-cost medications (typically generics) before the plan will cover a more expensive brand-name drug for a condition.

**451. A**

Long-term care insurance covers services needed when a person cannot perform activities of daily living (like bathing, dressing, eating) due to chronic illness, disability, or cognitive impairment.

**452. B**

Activities of daily living (ADLs) are basic self-care tasks including bathing, dressing, eating, toileting, transferring (moving), and continence. Inability to perform ADLs often triggers long-term care benefits.

**453. C**

A benefit trigger is the condition that must be met before long-term care insurance benefits begin. Common triggers include inability to perform a certain number of ADLs or cognitive impairment.

**454. D**

Mental health parity means that when a plan does cover mental health and substance use disorder benefits, the financial requirements and treatment limitations applied to them may be no more restrictive than those applied to medical and surgical benefits. Parity does not by itself require a plan to offer mental health coverage; that obligation comes from the essential health benefits rules for individual and small group plans.

**455. A**

Community rating is a method of setting premiums where everyone in a geographic area pays the same base rate, regardless of individual health status. The ACA requires modified community rating.

**456. B**

Experience rating bases premium rates on the actual claims history and experience of a specific group. Groups with fewer claims may receive lower rates, while those with more claims pay higher rates.

**457. A**

In managed care plans, particularly HMOs, the gatekeeper is the primary care physician who coordinates all patient care and must authorize referrals to specialists to ensure medical necessity and cost control.

**458. D**

Quantity limits cap how much of a drug the plan covers over a set period, typically based on FDA labeling and safety guidelines. They differ from step therapy (trying preferred drugs first) and prior authorization (plan approval before coverage begins). Amounts beyond the limit generally require an exception request supported by the prescriber.

**459. D**

For medications taken continuously - blood pressure or cholesterol drugs, for example - plans commonly offer 90-day mail-order supplies at a lower total copayment than three separate 30-day retail fills. The formulary still applies: mail order changes the dispensing channel and the cost-sharing, not what is covered.

**460. D**

For Part D, creditable coverage is drug coverage expected to pay at least as much as standard Part D on average. Keeping creditable coverage lets a beneficiary delay Part D enrollment without incurring the permanent late enrollment penalty. The older HIPAA meaning of creditable coverage, offsetting pre-existing condition exclusion periods, is largely obsolete because the ACA eliminated those exclusions in major medical coverage.

**461. A**

High-risk pools are state-sponsored health insurance programs designed to cover individuals who cannot obtain coverage in the private market due to pre-existing conditions. The ACA reduced their need.

**462. B**

CHIP (Children's Health Insurance Program) is a federal-state program providing health coverage to uninsured children in families with incomes too high for Medicaid but too low for private insurance.

**463. C**

Adverse selection occurs when individuals with higher health risks are more likely to purchase insurance, while healthier people may decline coverage, leading to a disproportionate number of claims.

**464. D**

Moral hazard in health insurance is the tendency for insured individuals to use more medical services or take less care of their health because they don't bear the full cost of their decisions.

**465. C**

An attending physician statement is a report the underwriter requests, with the applicant's written authorization, from a physician who has treated the applicant. It provides detail the application and MIB codes cannot - diagnoses, treatment dates, and prognosis. The MIB, by contrast, is an industry database of brief coded underwriting information shared among member insurers.

**466. A**

When health history raises the expected risk but the applicant is still insurable, the insurer can issue a rated - also called substandard - policy at a higher premium. That differs from an exclusion rider, which carves a named condition out of coverage, and from declination. Disability insurers may also shorten the benefit period or lengthen the elimination period for substandard risks.

**467. B**

Metal levels reflect actuarial value - the average percentage of covered costs a plan pays across a standard population: roughly 60% for Bronze, 70% for Silver, 80% for Gold, and 90% for Platinum. Higher metal levels mean higher premiums but lower out-of-pocket costs. The levels say nothing about provider quality or claims service.

**468. D**

Guaranteed renewability means the insurer cannot refuse to renew coverage as long as premiums are paid. The insurer can increase premiums for the entire class but cannot single out individuals.

**469. A**

Under the ACA a health plan may not retroactively cancel coverage except where the individual commits fraud or makes an intentional misrepresentation of material fact, and the insurer must give at least 30 days advance written notice. Ordinary administrative errors, a change in health status, or the cost of claims are not grounds for rescission. Prospective termination for nonpayment of premium is a different matter and is still allowed.

**470. B**

The SBC is a standardized document required by the ACA that explains health plan coverage in plain language using a consistent format, making it easier to compare different plans.

**471. C**

MLR is the percentage of premium dollars insurers must spend on medical care and quality improvement. The ACA requires 80% for individual/small group and 85% for large group plans.

**472. D**

A QHP is a health insurance plan certified by the Health Insurance Marketplace to meet ACA standards, including essential health benefits, cost-sharing limits, and other consumer protections.

**473. A**

Non-grandfathered plans must cover a defined list of recommended preventive services - immunizations, blood pressure and cancer screenings, well-child visits, and more - without any cost-sharing when delivered in network. Out-of-network preventive care, and diagnostic services ordered because of symptoms, can still involve normal cost-sharing.

**474. C**

Plans that offer dependent child coverage must make it available until the child turns 26. Eligibility does not depend on the child's marital status, student status, financial dependence, residence, or employment. The child's own spouse and children, however, are not required to be covered by the parent's plan.

**475. C**

Cost-sharing reductions are subsidies that lower out-of-pocket costs (deductibles, copays, coinsurance) for eligible individuals who choose Silver tier Marketplace plans and meet income requirements.

**476. B**

Catastrophic plans pair low premiums with a very high deductible. They are limited to people under 30 or those granted a hardship or affordability exemption. They cover the essential health benefits after the deductible, plus at least three primary care visits and free in-network preventive care before it - but premium tax credits cannot be applied to them.

**477. A**

In many HMO arrangements, the primary care physician coordinates routine care and may provide referrals to specialists within the network.

**478. B**

A preferred provider organization usually lets members use network providers at better cost sharing while still offering some coverage for out-of-network care.

**479. C**

Gatekeeper HMO models commonly require the primary care physician to coordinate specialist referrals so care stays within the plan's managed network.

**480. D**

PPO networks are built around participating providers that agree to plan terms, which can reduce the member's cost sharing compared with out-of-network care.

**481. A**

A point-of-service plan often blends HMO-style coordination with the option to use providers outside the network, usually at a higher cost.

**482. B**

A provider network is the group of medical providers and facilities that have a contractual relationship with the health plan.

**483. C**

Many managed-care plans encourage network use. Out-of-network care may be covered at a lower level or may create higher out-of-pocket costs, depending on the plan.

**484. D**

Utilization review is a cost-control and care-management process used to evaluate whether covered services are medically necessary or appropriate.

**485. A**

Preauthorization means the plan requires approval before certain services are provided, often to confirm coverage and medical necessity.

**486. B**

Federal rules require plans to cover emergency services without prior authorization and without imposing higher cost sharing for out-of-network emergency care. Whether a situation is an emergency is judged by the prudent layperson standard, meaning what a reasonable person would believe, not the final diagnosis. The No Surprises Act additionally protects patients from balance billing for out-of-network emergency services.

**487. C**

A deductible is the amount the insured must pay for covered services before the plan starts paying according to the policy terms.

**488. D**

Coinsurance is a cost-sharing percentage. For example, after the deductible, the plan may pay a percentage and the insured pays the remaining percentage.

**489. D**

A family deductible caps the household's total deductible exposure. Combined covered expenses - commonly with no single member counting more than their individual deductible - satisfy it, after which the plan pays benefits for every family member as though each individual deductible had been met.

**490. B**

An out-of-pocket maximum caps the insured's covered cost sharing for a plan period. Premiums and noncovered services may not count, depending on plan terms.

**491. C**

Major medical coverage is designed for a broad range of medical expenses, often including hospital, physician, surgical, and related services under the policy.

**492. D**

Hospital expense benefits are associated with covered hospital charges such as room, board, and related inpatient services, depending on policy terms.

**493. A**

Surgical expense benefits are designed to help pay for covered surgical services, subject to the policy's limits and exclusions.

**494. B**

Limited-benefit policies may provide narrower coverage than major medical policies. Applicants should understand what is and is not covered.

**495. C**

UCR concepts are used by some plans to evaluate reasonable charges for covered medical services in a geographic or market context.

**496. D**

Exclusions limit coverage by identifying items, services, or circumstances that are not covered. Candidates should read policy language carefully.

**497. A**

The policy's definition of disability controls whether the insured meets the requirement for benefits. Definitions can differ by policy.

**498. B**

The elimination period is the waiting period after disability begins before benefits become payable under the policy.

**499. C**

The benefit period is the maximum period that disability benefits may be paid, subject to policy terms.

**500. D**

Residual disability benefits may provide partial benefits when the insured returns to work but suffers reduced earnings due to disability.

**501. A**

An own-occupation definition asks only whether the insured can perform the substantial duties of the occupation they were actually working in - the most favourable definition for the insured, because they may qualify even if able to do other work. Option B is the 'any-occupation' definition, which is harder to satisfy. Option C describes the stricter Social Security-style standard. Option D describes an income-replacement (residual or partial) test, not a total-disability definition. Exact policy wording controls in every case.

**502. B**

Any-occupation definitions generally look beyond the insured's own job and may consider other suitable work, depending on policy wording.

**503. C**

A noncancelable disability income policy generally protects both renewability and premium rates when premiums are paid as required.

**504. D**

Guaranteed renewable coverage protects continued coverage, but premiums may be increased for a class of insureds under the policy's terms.

**505. A**

The entire contract provision identifies the documents that make up the full insurance contract and limits reliance on outside statements.

**506. B**

This provision limits the time period for the insurer to contest certain statements, subject to fraud and policy terms.

**507. C**

A grace period gives the policyowner a limited time after the due date to pay the premium, subject to policy terms.

**508. D**

Reinstatement is the process of restoring a lapsed policy after the insured satisfies the policy's reinstatement requirements.

**509. A**

Notice of claim provisions require the insured or claimant to notify the insurer within the policy's required time frame.

**510. B**

Proof of loss is information or documentation the insurer uses to evaluate whether a claim is payable under the policy.

**511. C**

Legal actions provisions often set timing rules for lawsuits related to claim disputes, subject to applicable law and policy terms.

**512. D**

Some health or accident policies may include death benefits. A beneficiary provision explains how the named recipient may be changed.

**513. A**

In group coverage, the employer or sponsoring organization commonly owns the master policy, while covered members receive certificates or coverage summaries.

**514. B**

Group members commonly receive certificates or summaries that explain their benefits under the master group policy.

**515. C**

A probationary or waiting period is the length of service a newly hired employee must complete before becoming eligible for group coverage, which discourages enrolling workers who leave quickly. It is distinct from the eligibility or enrollment period, which is the limited window, commonly 31 days, during which a newly eligible employee may enroll without providing evidence of insurability.

**516. D**

A contributory plan requires covered employees to contribute toward the cost of coverage, while a noncontributory plan is fully paid by the employer or sponsor.

**517. A**

COBRA generally allows eligible people to continue group health coverage temporarily after qualifying events, subject to federal rules and plan requirements.

**518. B**

Coordination of benefits helps prevent duplicate overpayment and determines how multiple health plans share payment responsibility.

**519. C**

A conversion privilege may allow a person losing group coverage to obtain individual coverage without the same underwriting process, subject to plan and legal requirements.

**520. D**

Medicare Part A is commonly described as hospital insurance, though exact benefits, costs, and eligibility should be verified through official Medicare resources.

**521. A**

Medicare Part B is commonly described as medical insurance for certain doctor, outpatient, and related services, subject to official program rules.

**522. B**

Medicare Advantage, or Part C, is generally a private-plan way to receive Medicare benefits, subject to federal rules and plan details.

**523. C**

Medicare Supplement, or Medigap, policies are designed to help with certain out-of-pocket costs under Original Medicare, subject to standardized plan rules.

**524. D**

Long-term care insurance helps cover certain long-term care services when the insured meets benefit triggers such as needing help with activities of daily living.

**525. A**

Activities of daily living commonly include basic self-care functions such as bathing, dressing, eating, toileting, transferring, and continence.

**526. B**

The elimination period in long-term care insurance is a waiting period before benefits are payable once the insured otherwise qualifies, depending on policy terms.

**527. C**

A noncancelable policy generally cannot be canceled by the insurer during the stated term as long as premiums are paid, and premiums usually cannot be changed for that policy alone.

**528. D**

Guaranteed renewable coverage generally requires the insurer to renew the policy if premiums are paid, but premiums may be changed for a class of insureds under the policy terms.

**529. A**

Optionally renewable policies give the insurer more discretion not to renew at specified times, subject to the policy language and applicable rules.

**530. B**

A probationary period is a waiting period after policy issuance before coverage begins for certain sicknesses, helping the insurer avoid immediate claims for existing conditions.

**531. C**

The time limit on certain defenses provision restricts how long an insurer may use certain application misstatements to deny claims, while still allowing exceptions such as fraud where permitted.

**532. D**

Reinstatement provisions explain the conditions under which a lapsed health policy may be restored, such as application, premium payment, and insurer approval rules.

**533. A**

A grace period gives the policyowner limited extra time to pay a premium after its due date. Coverage handling depends on policy terms and applicable law.

**534. B**

This provision allows the insurer to require reasonable examinations related to a claim, and autopsy where not prohibited by law, to verify claim information.

**535. C**

The legal actions provision limits when a lawsuit may be brought, usually requiring time for claim review and setting an outside deadline after proof of loss.

**536. D**

A revocable beneficiary can usually be changed by the policyowner. An irrevocable beneficiary generally has stronger rights and may need to consent.

**537. A**

Underwriting helps the insurer evaluate an applicant's risk characteristics and determine acceptance, rating, exclusions, or other policy terms where allowed.

**538. B**

Medical history is commonly relevant because it may affect expected health claims. The exact use of underwriting factors depends on the product and legal requirements.

**539. C**

An exclusion rider may limit coverage for a named condition or risk. Candidates should remember that legality and use vary by product and jurisdiction.

**540. D**

A preexisting condition limitation addresses conditions that existed before the policy effective date. Modern rules vary by policy type, so candidates should avoid assuming one rule applies everywhere.

**541. A**

Proof of loss is claim documentation submitted to the insurer so it can evaluate whether benefits are payable under the policy.

**542. B**

Notice-of-claim provisions require timely notification so the insurer can start the claim process and request needed forms or information.

**543. C**

Claims can be denied when the expense falls outside policy coverage, is excluded, lacks required proof, or fails another policy condition.

**544. D**

Coordination of benefits rules determine payment order when more than one health plan covers the same person, helping avoid duplicate recovery beyond covered expenses.

**545. D**

Conditionally renewable policies let the insurer refuse renewal only on grounds stated in the policy, such as reaching a certain age or leaving a job - never deteriorating health. The classification sits between optionally renewable (the insurer may decline renewal for any reason on a premium due date) and guaranteed renewable (the insured has the right to renew, though premiums may rise by class).

**546. B**

Utilization review examines the medical necessity, appropriateness, or efficiency of services under the health plan's rules.

**547. C**

A waiver of premium rider can keep coverage in force without premium payments if the insured satisfies the rider's disability definition and waiting-period requirements.

**548. D**

Guaranteed insurability riders allow future increases at specified times or events without new medical underwriting, subject to the rider's limits.

**549. A**

Critical illness insurance pays a defined benefit when the insured meets the policy requirements for a covered illness such as cancer, heart attack, or stroke.

**550. B**

Hospital indemnity coverage typically pays a set benefit for covered hospitalization events, such as per day or per admission, depending on policy terms.

**551. C**

Accident-only policies limit benefits to covered accidental injuries or losses. They generally do not cover sickness unless specifically provided.

**552. D**

Some dental policies use waiting periods before certain services, especially major services, become covered. The exact waiting period depends on the policy.

**553. A**

Vision coverage is typically a limited-benefit plan for routine eye care and eyewear, subject to allowances, copays, networks, and frequency limits.

**554. B**

Specified disease policies provide benefits for named conditions, such as cancer, according to policy definitions and limits.

**555. C**

Inflation protection can increase benefit amounts over time so long-term care benefits are less likely to lose purchasing power as care costs rise.

**556. D**

The benefit period describes the maximum length of time or total pool of benefits available under a long-term care policy, depending on the policy design.

**557. A**

In group coverage, the master policy is issued to the employer or group sponsor, while covered individuals usually receive certificates or summaries of coverage.

**558. B**

A certificate explains the member's coverage under the group plan, but the master policy controls the full contract terms.

**559. C**

In a contributory plan, covered employees pay part of the premium. Participation rules may apply to reduce adverse selection.

**560. D**

Eligibility rules identify which employees or members qualify for coverage, such as full-time status, waiting period completion, or class membership.

**561. A**

COBRA gives eligible individuals the right to continue group health coverage for a limited time after qualifying events, usually by paying the required premium.

**562. B**

Unfair claims practices involve improper conduct such as unreasonable delays, misrepresentation, or failure to handle claims according to applicable standards.

**563. C**

Misrepresentation can mislead consumers about what a policy does or does not cover. Producers should explain coverage accurately and avoid false or exaggerated claims.

**564. D**

Twisting generally involves using misleading statements to persuade a consumer to replace existing coverage. Replacement discussions should be accurate and complete.

**565. A**

Clear disclosure helps consumers understand what they are buying. Producers should not imply that limited-benefit or supplemental policies are comprehensive major medical coverage.

**566. B**

Suitability focuses on whether a recommendation is appropriate for the consumer's needs, objectives, and situation, based on available information.

**567. B**

The insured first satisfies the $1,000 deductible. The remaining $5,000 is the amount subject to the 80/20 coinsurance split.

**568. B**

After the $1,000 deductible, $5,000 remains. The insured's 20% coinsurance share of $5,000 is $1,000, before considering any out-of-pocket maximum.

**569. C**

An out-of-pocket maximum caps covered cost-sharing, such as deductibles, coinsurance, and copayments, according to the plan's rules.

**570. D**

Prior authorization requires advance plan approval for certain services, drugs, or procedures. Lack of authorization may affect coverage or payment.

**571. A**

PPOs usually provide stronger benefits for in-network care and may impose higher cost-sharing, balance-billing exposure, or different rules for out-of-network care.

**572. B**

Specialty tiers hold the most expensive drugs - often biologics or injectables needing special handling or monitoring. Cost-sharing is the plan's highest, frequently coinsurance rather than a flat copay, and plans commonly require filling through a contracted specialty pharmacy that manages storage, shipping, and patient support.

**573. D**

Prescription plans often use tiers. Preferred generic drugs may have lower cost-sharing, while nonpreferred or specialty drugs may cost more.

**574. B**

When the member - rather than the prescriber - chooses the brand over an available generic, many plans charge the generic-tier copay plus the price difference between the two products. If the prescriber documents medical necessity for the brand, writing 'dispense as written' and supporting an exception request, the plan may instead cover it at normal brand cost-sharing.

**575. C**

Exclusions define what is not covered. Understanding exclusions helps consumers avoid assuming a policy pays for every possible expense.

**576. D**

The explanation of benefits and policy language help identify whether the denial relates to coverage, coding, missing information, network rules, or appeal rights.

**577. C**

The provision limits the contract to the printed policy and the attached copy of the application, so nothing outside those pages can be used against the insured. Verbal statements by a producer are excluded precisely because the provision also says no change is valid unless an executive officer of the insurer approves it in writing. Underwriting manuals are internal guidelines, never contract terms, and the application does count once it is physically attached.

**578. D**

The provision bars an insurer from using an innocent or negligent misstatement to void coverage or deny a claim once the policy has been in force for the stated period, which is two or three years depending on the version of the provision a state has adopted. Rescission and premium refund are contest remedies that are no longer available for a non-fraudulent error after that window closes. Arbitrarily cutting benefits is not a remedy this provision authorizes; the misstatement of age provision, not this one, allows a proportional benefit adjustment. Fraudulent misstatements may remain contestable.

**579. A**

The provision sets a graduated scale: 7 days for weekly premium policies, 10 days for monthly, and 31 days for any longer mode such as quarterly, semiannual, or annual. Monthly premiums get 10 days rather than 31, weekly get 7 rather than 15, and annual premiums get the full 31 days rather than 10. Coverage stays in force during the grace period, and any unpaid premium may be deducted from a claim paid in that window.

**580. B**

The standard reinstatement provision covers accidental injury immediately upon reinstatement but imposes a short waiting period, typically 10 days, before sickness is covered, which discourages someone from reinstating only after symptoms appear. Reinstatement is prospective, so it never fills the gap during the lapse. There is no 50 percent phase-in and no one-year sickness bar in the uniform provision.

**581. C**

Notice of claim is the first and quickest step, due within 20 days of the occurrence or start of the loss, with a reasonableness allowance for insureds who genuinely cannot comply. Proof of loss comes later, is more detailed, and carries a longer deadline that some states lengthen beyond the model's 90 days. The three-year period is the outer limit for bringing legal action, and 60 days is the waiting period before suit may be filed.

**582. D**

If claim forms are not furnished within the stated period, commonly 15 days after notice, the claimant is deemed to have met the proof requirement by submitting written proof describing the occurrence, character, and extent of the loss. The insurer still gets to evaluate that proof, so the claim is not automatically payable. Forcing the claimant to wait would defeat the provision's purpose, and a direct fine to the claimant is not part of this provision.

**583. C**

The uniform provision sets proof of loss at 90 days, measured from the date of loss or, for periodic benefits such as disability income, from the end of each benefit period. Twenty days is the notice of claim deadline, not proof of loss. The provision also excuses late proof where it was not reasonably possible to comply, generally if furnished within about a year absent legal incapacity. Some states adopted a longer period than the model, so always confirm your own state's version.

**584. A**

The provision sets both a floor and a ceiling: a 60-day cooling-off window that gives the insurer time to investigate and pay, and an outer limit of about three years after proof of loss was due. Allowing immediate suit would remove the insurer's chance to settle voluntarily. The deadlines key off proof of loss rather than a written denial, and no surrender of the policy is required. States may adopt slightly different periods, so confirm your own state's version.

**585. B**

The provision gives the insurer a reasonable investigative right during a pending claim, but expressly places the cost on the insurer and conditions autopsy on state law permitting it. Limiting exams to once a year or shifting cost to the insured contradicts the wording. Some states restrict or prohibit autopsies, so an unconditional autopsy right does not exist, and routine wellness screenings are unrelated to claim investigation.

**586. D**

Facility of payment lets the insurer settle a limited amount with a relative by blood or marriage who appears equitably entitled when the benefit would otherwise be payable to the insured's estate, or to a payee who is a minor or otherwise unable to give a valid release. It exists to avoid forcing a probate proceeding over a small sum, which is the opposite of waiting for a court-appointed executor. Producers have no claim on policy benefits, and unilaterally converting a benefit into an annuity is not part of the provision.

**587. A**

The provision avoids both extremes by scaling the benefit down to what the premium actually paid would have bought at the riskier classification, which keeps the contract in force instead of voiding it. Outright denial is not authorized, since the insured did not lie on the application. Full payment would let the insured buy extra risk for free, and the provision works in the insured's favor as well by refunding premium when the change is to a less hazardous job.

**588. B**

Age misstatement is treated as a pricing error, not a contest, so the remedy is a proportional benefit adjustment rather than rescission. Rescission would be inconsistent with the time limit on certain defenses once the contestable period has run. The provision does not create a back-premium billing right, and an honest age error is not automatically a fraud referral.

**589. C**

The illegal occupation provision removes liability for loss stemming from committing a felony or working in an illegal trade, and the intoxicants and narcotics provision removes liability for loss sustained while intoxicated or under a narcotic not taken on a physician's order. Unpaid premium simply lets the insurer net an overdue premium out of a claim payment, and conformity automatically amends the contract to match state law. The remaining choices address duplicate coverage, benefit-to-income limits, and administrative rights, not conduct.

**590. D**

This average earnings clause protects against overinsurance by prorating benefits down when the combined disability coverage from all sources exceeds the insured's earnings, while typically guaranteeing a small minimum monthly payment. It operates at claim time, not as an underwriting document requirement. Inflation indexing is a cost-of-living rider, and ordering coverage priority between policies is coordination of benefits, a different concept.

**591. A**

Apparent authority arises from the appearance the principal creates in the mind of a third party, so the insurer may be bound even though no such power was actually granted. Express authority is what the agency contract literally states in writing, and implied authority is what is customary and necessary to carry out express powers. Fiduciary duty concerns handling client money and trust, not the scope of authority to act for the insurer.

**592. B**

Aleatory refers to the unequal exchange of value: an insured may pay a few premiums and collect a large benefit, or pay for decades and collect nothing. A one-sided enforceable promise describes a unilateral contract, and a take-it-or-leave-it

form drafted by the insurer describes adhesion. Duties triggered by specified events describe the conditional nature of the contract.

**593. C**

Adhesion means the applicant had no chance to negotiate wording, so the drafting party bears the cost of its own imprecision and ambiguity is resolved against the insurer. Favoring the insurer would reward sloppy drafting. Sales illustrations are not contract terms under the entire contract provision, and courts do not split the difference between readings.

**594. D**

Unilateral means the promise runs one way: the insurer is bound to pay covered claims, but the insured is never legally compelled to continue paying and may lapse the policy without being sued. Equal value at issue would contradict the aleatory nature of the contract. Insurable interest is a separate requirement and is evaluated at application, not proven in court as a condition of effectiveness.

**595. A**

Statements by an applicant are representations, judged by whether they are substantially true and material, which is why an innocent error rarely voids coverage. Warranties demand literal exactness and are generally reserved for commercial contracts, not personal health applications. The statements are far from consequence-free, since a material misrepresentation can support rescission during the contestable period.

**596. B**

Concealment is the silent withholding of a material fact the applicant knew and should have disclosed, and it can support rescission even without a specific question when the fact is clearly material to the risk. Twisting is inducing a policy replacement through misrepresentation, and rebating is giving something of value outside the contract to induce a sale. Estoppel prevents a party from asserting a right it has already given up, which is unrelated to the applicant's silence.

**597. C**

Waiver is the voluntary giving up of a known right, and estoppel is the legal consequence that stops the insurer from later reclaiming that right after the insured relied on the pattern of acceptance. Subrogation concerns recovery from a responsible third party, and indemnity limits an insured to actual loss so no profit results. Coinsurance is a cost-sharing formula and has nothing to do with premium timing.

**598. D**

For personal insurance, insurable interest is tested at inception, so an applicant must show a genuine stake such as insuring themselves, a spouse, or a dependent, which prevents wagering on a stranger's health. Requiring it only at claim time would defeat that anti-wagering purpose. Personal insurance does not require continuous insurable interest the way property insurance does, and the concept is certainly not limited to property coverage.

**599. A**

Adverse selection is the tendency of higher-risk people to seek coverage more aggressively, so insurers respond with evidence of insurability, risk classification, and waiting periods that keep pricing aligned with risk. Charging everyone the same regardless of health would invite exactly that imbalance. Commission structures affect distribution economics, and a longer free look protects consumers but does nothing to screen risk. Note that ACA-compliant individual major medical is guaranteed issue and may not use medical underwriting or preexisting condition exclusions, so these practices now apply mainly to excepted benefits.

**600. B**

Indemnity limits recovery to actual expense incurred, which is why coordination of benefits and other insurance clauses exist to prevent stacking payments into a windfall. Paying twice for the same expense is the outcome indemnity is meant to block. A flat daily payment describes a valued or indemnity-schedule product such as hospital indemnity, and claim order does not determine benefit amounts.

**601. C**

MIB codes are brief flags contributed by member companies, not verified diagnoses, so member rules require independent confirmation before any adverse decision. Declining solely on an MIB code violates those rules. The data is not hidden from underwriters, since sharing with members is the whole point, and disclosing an applicant's health information to an employer would be an improper release.

**602. D**

MIB is a nonprofit organization funded by its member insurers that stores brief coded information gathered from prior applications, helping members spot undisclosed history. It is not a government body and licenses no one. It is distinct from consumer credit bureaus, which produce credit reports, and it neither adjudicates nor pays claims.

**603. A**

FCRA requires an adverse action notice that tells the consumer the decision was based on a report and names the reporting agency, so the consumer can go to that agency to review and dispute the file. The insurer is not the party obligated to hand over the report itself; the reporting agency provides the disclosure. Signing an application does not waive these rights, and FCRA does not impose an automatic payment to the applicant.

**604. B**

The distinguishing feature is the interview method: an investigator speaks with neighbors, friends, employers, or associates to develop information about character and mode of living. Because it is more intrusive, the applicant must be notified that such a report may be obtained and may request disclosure of its nature and scope. An ordinary consumer report is compiled largely from records rather than interviews, and both types come from outside reporting agencies.

**605. C**

The producer is the insurer's field underwriter and has a duty to record answers truthfully; omitting a known material fact is a misrepresentation that can support rescission during the contestable period and could expose the producer to license action. The applicant's signature does not cure a known omission the producer helped conceal. Private notes and blank applications both keep material information out of the underwriting file, which is the same problem.

**606. D**

A conditional receipt makes coverage contingent on the applicant meeting the insurer's underwriting standards, typically dating back to the application or the completed medical exam, whichever is later. Coverage regardless of insurability describes a binding receipt, which is far less common in health insurance. Coverage does exist before delivery when the condition is met, and it remains subject to the ordinary contestable period.

**607. A**

Because coverage was not in force during underwriting, the insurer needs assurance that the risk has not changed between application and delivery, which the statement of continued good health provides. Waiving the free look would strip a consumer protection and is not permitted as a routine delivery step. A conditional receipt is issued only when premium accompanies the application, so it cannot be created at delivery to backdate coverage, and an approved application does not require a fresh attending physician statement at delivery.

**608. B**

Without a premium and receipt, there is no consideration and therefore no coverage during underwriting, so the contract takes effect at delivery when premium and the good health statement are obtained. Signing an application is only an offer. Internal approval and exam dates matter for backdating under a conditional receipt, but no receipt was issued in this fact pattern.

**609. C**

Replacement rules exist to prevent coverage gaps and uninformed switches, so the client gets a comparison notice and the old policy is not dropped until the replacement is genuinely in force. Canceling first, or dropping the old policy on the strength of a conditional receipt, can leave the client uninsured if the new application is declined or rated. The existing insurer's consent is not a prerequisite to replacement, and no producer can guarantee claim outcomes.

**610. D**

The authorization is a limited, revocable permission that lets providers release protected health information to the insurer for the stated purposes, and it must describe what will be disclosed and to whom. It does not convey ownership of records, which remain with the provider and the patient. It also does not waive adverse action disclosures under FCRA, and it remains revocable by the applicant at any time.

**611. A**

Standardization fixes the benefit package attached to each letter, which converts a confusing market into an apples-to-apples comparison where price, rating method, and service are the real variables. Premiums are emphatically not standardized and vary widely by insurer, rating approach, and area. The federal government does not underwrite or pay Medigap benefits, and many insurers may offer the same letter in a state.

**612. B**

Core benefits found in every lettered plan include Part A hospital coinsurance with 365 extra lifetime days, Part B coinsurance, the first several pints of blood, and Part A hospice coinsurance. The Part A deductible, skilled nursing facility coinsurance, and the Part B deductible are additional benefits found only in certain plan letters, not in the core package that every letter must carry.

**613. C**

The six-month window requires two conditions together, age 65 or older and Part B enrollment, and during it an applicant has guaranteed issue rights with no medical underwriting. It is not tied to Part A entitlement alone, and the seven-month window around the 65th birthday is the Medicare initial enrollment period, a different enrollment event.

**614. D**

Federal standards cap the Medigap preexisting condition exclusion at six months and require credit for months of prior creditable coverage, which usually eliminates the waiting period for someone moving directly from other coverage. A twelve-month period, or one that ignores prior coverage, would defeat that protection. Applying during open enrollment does not by itself eliminate the waiting period; prior creditable coverage does.

**615. A**

Part C plans replace the delivery of Original Medicare benefits through a private carrier that must provide at least what Parts A and B cover, usually with network rules and often with added dental, vision, or drug coverage. A supplemental policy sold alongside Original Medicare describes Medigap, which works very differently. Medicare Advantage is not a government-run cost-sharing program, and it is not a savings account arrangement.

**616. B**

Medigap is designed to fill gaps in Original Medicare only, so it pays nothing toward Medicare Advantage cost sharing, and it is illegal to sell a Medigap policy to someone known to be enrolled in Part C unless that person is disenrolling and returning to Original Medicare. Whether the Advantage plan includes drug coverage is irrelevant to this prohibition. An acknowledgment that the Medigap policy pays second would not create benefits that do not exist.

**617. C**

Medicare Supplement marketing standards flatly bar knowingly selling a duplicate policy, because the second one cannot pay benefits the first already covers and the consumer simply pays two premiums. Using a different plan letter does not solve the duplication, since the core benefits overlap. A consumer waiver cannot make an unfair trade practice lawful, and producers must obtain a signed statement about existing coverage before completing a sale.

**618. D**

An excess charge arises when a provider who does not accept Medicare assignment bills more than the Medicare-approved amount, leaving the beneficiary responsible for the difference within legal limits. The Part B coinsurance, the income-related premium adjustment, and the late enrollment penalty are separate cost items unrelated to a provider's billing behavior, and no Medigap plan covers premium surcharges.

**619. A**

Plans K and L trade lower premiums for partial payment of specified cost-sharing items such as the Part A deductible, skilled nursing facility coinsurance, Part B coinsurance, blood, and hospice coinsurance, balanced by an annual out-of-pocket maximum after which the plan pays covered costs in full for the remainder of the calendar year. The Part A hospital coinsurance and the 365 additional lifetime hospital days are still paid in full, and the plans carry an out-of-pocket limit rather than a benefit maximum. High deductible Plans F and G and Medicare SELECT are separate, distinct Medigap structures.

**620. B**

Part D is optional and delivered by private stand-alone drug plans or by Medicare Advantage plans that include drug coverage, with a lasting premium penalty designed to discourage waiting until drugs are needed. Enrollment is not automatic with Part A, the late enrollment penalty lasts for as long as the beneficiary has Part D coverage rather than ending after a year, and Medigap policies sold since Part D began may not include drug coverage.

**621. C**

Medigap benefits are derivative: they can only supplement what Medicare itself covers, and Medicare does not pay for ongoing custodial care, so no plan letter fills that need. Plan G is a comprehensive supplement but is still bound by that limit. There is no custodial care waiting period that unlocks the benefit, and buying a second Medigap policy would be prohibited duplication.

**622. D**

Suitability rules require a producer to ask about and record existing coverage to avoid duplication, and Medigap policies carry a free look, commonly 30 days, letting the buyer return the policy for a full refund. Implying government endorsement is a misrepresentation, since Medigap is private insurance. Prepaying premium does not freeze rates, and responsible comparison also considers the insurer's rating method, rate history, and service.

**623. A**

An individual buyer generally gets no above-the-line deduction and must itemize, clearing an AGI floor before any benefit appears, which means most taxpayers deduct nothing. A blanket full deduction is available in narrower situations such as the self-employed health insurance deduction, not to individuals generally. Bundling disability coverage does not create deductibility, and saying it is never deductible ignores the itemized route.

**624. B**

The controlling rule is who paid with what dollars: because the premiums were not deducted, the benefits come back tax free. Full taxation applies where an employer paid the premium and took a deduction. Disability benefits are ordinary in

character, not capital gains, and there is no rule taxing only the portion above prior salary.

**625. C**

When the employer deducts the premium and the employee is not taxed on it, the benefits become taxable income to the employee, keeping the dollars taxed exactly once. Group status by itself does not create exemption; the premium source does. The employer has no benefit income to report, and elimination periods affect when benefits begin, not how they are taxed.

**626. D**

HSA eligibility is defined by the coverage a person has, not by age or tenure: an HDHP is required, disqualifying coverage such as a general purpose FSA or Medicare enrollment ends eligibility, and dependents cannot open their own account. Ordinary group plans with low deductibles do not qualify as HDHPs, there is no earned income or age requirement, and Medicare enrollment specifically stops HSA contributions rather than enabling them.

**627. A**

HSA distributions are tax free only when used for qualified medical expenses; any other use is taxable and carries an additional penalty for accountholders below the applicable age threshold. The penalty is waived at that age and on death or disability, but not at 45. The entire nonqualified distribution is taxed, not just earnings, and the account does not have to be closed.

**628. B**

The deduction is taken above the line, so it reduces AGI whether or not the taxpayer itemizes, and it covers the self-employed person's own family premiums up to the business's net earnings. It is also unavailable for any month the taxpayer could participate in a subsidized plan through an employer or a spouse's employer. The itemized medical expense route with an AGI floor is the fallback rule for individuals generally, not for the self-employed.

**629. C**

BOE coverage reimburses ongoing business costs such as rent, utilities, and staff salaries, so the premium is an ordinary business expense and the benefit is business income, largely neutralized because the expenses it pays are themselves deductible. Making premiums deductible and benefits tax free would create a double tax advantage the rules do not allow. The policy is owned and deducted by the business entity, not personally.

**630. D**

Because the corporation is the beneficiary of its own coverage, the premium is a nondeductible personal-type cost to the business and the offsetting benefit comes in tax free. Deducting premiums while receiving tax-free benefits is not permitted. The executive receives nothing under a key person policy, so nothing is taxable to him, and the tax-free character of the benefit follows from the nondeductible premium.

**631. A**

The birthday rule looks only at month and day, so the parent whose birthday comes first in the calendar year has the primary plan, and the year of birth is irrelevant. The parent's age plays no role, only the position of the birthday within the year. Length of coverage is a tiebreaker used in other coordination situations, such as when both parents share the same birthday, and custodial-parent rules apply only when the parents are divorced or separated.

**632. B**

Non-occupational coverage deliberately excludes work-related injury and illness, assuming workers compensation will respond, which lowers the premium; occupational coverage responds 24 hours a day regardless of where the disability arose. The term describes where the disability arose, not whether the insured is currently employed or in a particular occupation. It is not limited to sickness only, and it does not supplement workers compensation for on-the-job claims.

**633. C**

Subrogation lets the insurer step into the insured's shoes and recover from the responsible party what it already paid, which enforces the indemnity principle by preventing a double recovery for one loss. Letting the insured keep both the benefits and the settlement for the same bills would be exactly that double recovery. The health plan pays first and recovers afterward, and the reimbursement flows to the plan, not from it.

**634. D**

A residual benefit is proportional and income-based, scaling the payment to the measured loss of earnings when the insured returns to work at reduced capacity. A traditional partial disability benefit is simpler, paying a set fraction such as half the total benefit for a stated number of months, often only after a period of total disability. Neither benefit is limited by cause of disability, and residual benefits exist precisely because the insured is no longer totally disabled.

**635. A**

Group health contracts almost always exclude occupational injuries and illnesses, leaving workers compensation as the exclusive source of benefits for a work-related claim. Reversing that order would shift a statutory employer obligation onto the health plan. Group health coverage does not replace lost wages, and the employee cannot elect which program is

primary for an occupational claim.

**636. B**

Newborn coverage rules provide automatic protection from the moment of birth, including congenital conditions, so long as the policyholder gives notice and pays any additional premium within the required period. Excluding congenital conditions would defeat the purpose of automatic coverage. Making coverage begin on the date of notice would leave the infant unprotected during the highest-risk period, and coverage cannot simply run to the anniversary without the required notice and premium.

**637. C**

HIPAA defines creditable coverage broadly: it includes group health plans, individual health insurance coverage, Medicare Parts A and B, Medicaid, military health coverage, and several other public programs. Coverage consisting solely of excepted benefits, such as stand-alone dental or vision, does not count. There is no minimum number of years required. See 29 U.S.C. 1181(c).

**638. A**

HIPAA gives employees who lose other coverage a special enrollment right in their employer's plan, provided enrollment is requested no later than 30 days after the other coverage is exhausted or employer contributions toward it end. Similar 30-day special enrollment rights apply after marriage, birth, or adoption. Waiting for open enrollment is not required. See 29 U.S.C. 1181(f).

**639. B**

For termination of Medicaid or CHIP coverage, or upon becoming eligible for Medicaid/CHIP premium assistance, the employee has 60 days to request group plan enrollment, double the 30-day window that applies to loss of other coverage, marriage, birth, or adoption. See 29 U.S.C. 1181(f)(3).

**640. D**

HIPAA prohibits basing eligibility on health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Plans may still use employment-based classifications such as full-time versus part-time status and may impose uniform waiting periods. See 29 U.S.C. 1182.

**641. A**

The breach notification rule requires the covered entity to notify each affected individual without unreasonable delay and in no case later than 60 calendar days after the breach is discovered. The 30- and 90-day figures are distractors drawn from other compliance deadlines. See 45 CFR 164.404.

**642. B**

The Privacy Rule defines covered entities as health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a covered transaction. An employer in its capacity as employer is not itself a covered entity, though its group health plan is. See 45 CFR 160.103.

**643. C**

PHI is individually identifiable health information that is transmitted by or maintained in electronic media or in any other form or medium, so paper and oral information qualify along with electronic records. Information that cannot identify an individual is not PHI. See 45 CFR 160.103.

**644. A**

The minimum necessary rule applies to most uses, disclosures, and requests of PHI, but it does not apply to disclosures to or requests by a health care provider for treatment, to disclosures made to the individual, or to uses and disclosures made under a valid authorization. Treatment communications need full information to be safe. See 45 CFR 164.502(b).

**645. D**

Treatment, payment, and health care operations generally do not require authorization. Marketing, most uses of psychotherapy notes, and any sale of PHI do require a valid written authorization from the individual. See 45 CFR 164.508.

**646. B**

The Security Rule applies specifically to electronic PHI: covered entities must ensure its confidentiality, integrity, and availability and protect against reasonably anticipated threats. Paper and oral PHI are protected by the Privacy Rule rather than the Security Rule. See 45 CFR 164.306.

**647. A**

COBRA gives qualified beneficiaries at least 60 days to elect continuation coverage, running from the later of the date coverage would end or the date the election notice is provided. The 45-day figure is a distractor: that is the deadline for making the first premium payment after electing. See 29 U.S.C. 1161-1168 (COBRA).

**648. A**

When a qualified beneficiary is disabled under Social Security rules during the first 60 days of COBRA coverage, the standard 18-month period can be extended by 11 months, to 29 months total. During the 11-month extension the plan may charge the disabled beneficiary up to 150% of the plan's cost, versus the usual 102%. See 29 U.S.C. 1161-1168 (COBRA).

**649. C**

Divorce or legal separation, the covered employee's death, the employee's entitlement to Medicare, and a child's loss of dependent status each give the spouse or dependent up to 36 months of COBRA coverage. Termination of employment and reduction in hours are 18-month events, and a carrier change is not a qualifying event at all. See 29 U.S.C. 1161-1168 (COBRA).

**650. B**

COBRA's qualifying event for employees is termination of employment for reasons other than gross misconduct, or a reduction in hours. When the termination is for gross misconduct, the employer is not required to offer continuation coverage to the employee or the family. See 29 U.S.C. 1161-1168 (COBRA).

**651. A**

The Initial Enrollment Period lasts 7 months: it starts 3 months before the month a person turns 65 and ends 3 months after that month. Enrolling early in the window ensures coverage begins the month of eligibility. See medicare.gov.

**652. D**

Someone who misses the Initial Enrollment Period and has no special enrollment right must use the General Enrollment Period, which runs January 1 through March 31 each year; coverage starts the month after signing up, and late enrollment penalties may apply. October 15 to December 7 is Medicare's open enrollment for changing existing plan coverage, not for first-time Part B enrollment. See medicare.gov.

**653. B**

People who kept job-based coverage past 65 get a Special Enrollment Period that ends 8 months after the group health plan coverage or the employment ends, whichever comes first. Enrolling within this window avoids the late enrollment penalty. The 63-day figure relates to drug coverage gaps, not this SEP. See medicare.gov.

**654. C**

In each benefit period, once the Part A deductible is met, days 1 through 60 are covered with no daily coinsurance; days 61 through 90 carry a daily coinsurance amount; and after day 90 the patient can use up to 60 lifetime reserve days at a higher daily coinsurance. Lifetime reserve days do not renew with a new benefit period. The 80/20 structure describes Part B, not Part A. See medicare.gov.

**655. B**

The Part B penalty adds 10% to the monthly premium for each full 12-month period the person could have had Part B but did not sign up, and it generally lasts for as long as the person keeps Part B. Option D describes the premium Part A penalty structure, and 1% per month describes the Part D penalty. See medicare.gov.

**656. D**

The Part D penalty is 1% of the national base beneficiary premium for each full month the person went without Part D or other creditable drug coverage, so 20 months of delay adds about 20%. The penalty is recalculated from the national base premium each year and continues for as long as the person has Medicare drug coverage. See medicare.gov.

**657. A**

Guaranteed issue rights, also called Medigap protections, arise in situations such as losing other coverage through no fault of your own. When one applies, the insurer cannot deny the Medigap policy, cannot use medical underwriting to raise the price, and generally cannot impose waiting periods beyond limited pre-existing condition rules. See medicare.gov.

**658. C**

Outside the Medigap open enrollment period, and without a guaranteed issue right, insurers are not required to sell a Medigap policy: they may apply medical underwriting, charge a higher premium based on health, or refuse the application altogether. This is why timing a Medigap purchase matters. See medicare.gov.

**659. B**

Medigap open enrollment starts the first month a person is both enrolled in Part B and age 65 or older, lasts 6 months, and is a one-time opportunity that does not repeat each year. Medicare's annual open enrollment, by contrast, recurs every year for changing Medicare health and drug plan choices. See medicare.gov.

**660. D**

Medicaid is a joint federal-state program: each state administers its own program within federal guidelines, and costs are shared between the state and federal governments. Federal law requires states to cover certain mandatory groups, such

as low-income families, qualified pregnant women and children, and SSI recipients. See medicaid.gov.

**661. A**

States may operate a medically needy program for people with significant health needs whose income is too high for other eligibility groups. Such individuals spend down by incurring medical expenses; when those expenses exceed the difference between their income and the state's medically needy income level, Medicaid eligibility can begin. This contrasts with the categorically needy groups, who qualify by category and income alone. See medicaid.gov.

**662. B**

Medicaid generally pays only after other liable third parties, such as health insurers, liability insurers, and Medicare, have met their legal obligation to pay. States are required to take reasonable measures to identify such third-party liability. This is the opposite of primary coverage. See medicaid.gov.

**663. A**

Social Security defines disability as the inability to engage in any substantial gainful activity because of a medically determinable physical or mental impairment expected to result in death or to last for a continuous period of at least 12 months. Partial and short-term disabilities are not covered. See 42 U.S.C. 423(d) and ssa.gov.

**664. C**

SSDI has a waiting period defined as the earliest period of 5 consecutive calendar months during which the worker has been under a disability, so cash benefits begin with the sixth full month. This waiting period serves a role similar to an elimination period in private disability income insurance. See 42 U.S.C. 423(c).

**665. B**

A disabled worker under 65 becomes entitled to Medicare Part A hospital insurance beginning with the 25th month of entitlement to disability benefits, that is, after 24 months on the rolls. Disability is one of the ways a person can get Medicare before age 65. See 42 U.S.C. 426(b).

**666. D**

The Social Security definition turns on whether the worker can engage in any substantial gainful activity, considering age, education, and work experience, not merely whether she can do her previous job. An own-occupation private policy uses a more liberal standard, so a person can qualify privately while failing the Social Security test. See 42 U.S.C. 423(d).

**667. C**

Most group LTD contracts deduct other benefits received, including Social Security disability, from the LTD benefit dollar for dollar, so the insurer pays the difference and the claimant's total remains at the plan's benefit level. The offset runs in this direction: SSDI is not reduced because of private LTD payments. This integration keeps group LTD premiums lower.

**668. B**

One of the conditions for HSA contribution eligibility is that the individual is not enrolled in Medicare. Once Marta enrolls, she loses eligibility to contribute, even though she still has HDHP coverage. The account itself stays open, and distributions for qualified medical expenses remain tax free. See IRS Publication 969.

**669. C**

HSA contributions are deductible even for taxpayers who do not itemize, earnings inside the account are not taxed, and distributions are tax free when used for qualified medical expenses. Option D overstates the benefit: withdrawals for nonmedical purposes are taxable and may carry an additional tax. See IRS Publication 969.

**670. A**

HSA distributions not used for qualified medical expenses are included in gross income. The 20% additional tax, however, does not apply to distributions made after the owner reaches age 65, becomes disabled, or dies. So the withdrawal is taxable as ordinary income but escapes the penalty. See IRS Publication 969.

**671. D**

Health FSAs operate under a use-it-or-lose-it rule: unused amounts generally do not carry over to the following year. An employer may design the plan to allow a limited carryover of a capped amount or a short grace period, but neither is required, and full unlimited rollover is never permitted. See IRS Publication 969.

**672. B**

An HRA must receive contributions from the employer only; employees may not contribute, and there is no salary-reduction feature. Employer contributions and reimbursements for qualified medical expenses are not included in the employee's income. See IRS Publication 969.

**673. C**

The taxation of disability benefits follows who paid the premium. When the insured pays the entire cost of the coverage on an after-tax basis, the benefits are excluded from income; when the employer pays the premium, amounts the employee

receives for disability must be reported as income. See irs.gov on life and disability insurance proceeds.

**674. D**

The deduction is an adjustment to income available to the self-employed: sole proprietors with a net profit, partners with net self-employment earnings, and more-than-2% S corporation shareholders who received wages from the corporation. It is claimed on Schedule 1 of Form 1040 rather than as an itemized deduction. Ordinary employees and small C corporation shareholders do not qualify. See IRS Form 7206 instructions.

**675. A**

Part D drug coverage is offered to everyone with Medicare, but the plans themselves are sold and run by insurance companies and other private companies approved by Medicare, not by the government directly. Beneficiaries choose among competing private plans. See medicare.gov.

**676. B**

The penalty is 1% of the national base beneficiary premium multiplied by the number of full months the person was eligible but had neither Part D nor other creditable coverage. The amount is added to the monthly premium and generally continues for as long as the person has Medicare drug coverage. Option C describes the Part B late penalty pattern, not Part D. See medicare.gov.

**677. C**

Beginning in 2025, Part D enrollees' out-of-pocket costs for covered drugs are capped at $2,000 per year; once the cap is reached, the enrollee pays nothing more for covered Part D drugs that year. The cap is indexed annually ($2,100 in 2026). The $35 cap applies only to covered insulin products, not to premiums. See medicare.gov and cms.gov.

**678. D**

Plans place formulary drugs into tiers, and a drug on a lower tier generally costs the member less. When a needed drug sits on a non-preferred tier, the enrollee or prescriber may request a tiering exception, with the prescriber supplying a supporting statement of the medical reason; if granted, the plan charges the lower amount for that member. See medicare.gov.

**679. A**

Coverage is creditable when it is expected to pay on average as much as the standard Medicare prescription drug coverage. Medicare-eligible individuals who keep creditable coverage can delay Part D enrollment without incurring the late enrollment penalty, and plan sponsors must disclose creditable status to them annually. See cms.gov.

**680. B**

Under the ACA, no major medical plan can reject an applicant, charge more, or refuse to pay for essential health benefits because of a condition that existed before coverage started. That prohibition applies to medical expense coverage; insurers issuing individual disability income and long-term care policies still evaluate health history and may decline, rate, or modify coverage. See healthcare.gov.

**681. C**

Morale hazard is carelessness or indifference to loss that arises because the person is insured. It differs from moral hazard, which involves dishonesty, such as intentionally causing a loss or padding a claim. Adverse selection describes higher-risk people seeking coverage, not an insured's behavior after buying it.

**682. D**

Adverse selection is the tendency of people who are more likely to have claims to seek or keep coverage. Insurers counter it with tools such as limited enrollment periods, probationary or waiting periods, and careful risk classification, which prevent people from buying coverage only after a loss is imminent. Payment conveniences and advertising do not manage risk selection.

**683. A**

The MIB is a membership organization through which insurers share brief, coded information reported during past underwriting. When a new application conflicts with an MIB code, the underwriter is alerted to investigate further, which helps deter misrepresentation and fraud. It does not store full medical records, pay claims, or set rates.

**684. B**

The agent is the first line of underwriting: he or she sees the applicant in person, asks the application questions, records answers completely and accurately, and passes along relevant observations. The home office underwriter, not the agent, makes the final decision to issue, rate, or decline, and the agent neither sets premiums nor examines applicants medically.

**685. C**

Occupation is a central rating factor in disability income underwriting because the duties a person performs drive both the likelihood of disabling injury and the difficulty of returning to work. Insurers group occupations into classes, and applicants in hazardous classes face higher premiums, longer elimination periods, shorter benefit periods, or limited monthly benefits.

**686. A**

An indemnity approach pays a stated dollar amount per day or event no matter what expenses are actually incurred. An expense-incurred plan reimburses actual covered charges up to policy limits, while a service plan arranges for care itself, paying providers directly for services rather than paying cash to the insured.

**687. D**

The insured first pays the $1,000 deductible, leaving $4,000 of covered charges. The insurer then pays 80% of that amount ($3,200) and the insured pays the 20% coinsurance share ($800). His total is $1,000 plus $800, or $1,800.

**688. B**

A stop-loss (out-of-pocket) limit caps the insured's share of covered expenses. After deductible and coinsurance payments accumulate to the limit, coinsurance ends and the insurer pays covered charges in full for the remainder of the period. It protects the insured against catastrophic cost sharing; it does not end coverage or change the deductible.

**689. C**

Under a UCR approach, the insurer compares the provider's bill with what other providers in the same area typically charge for the same service and pays up to that prevailing level. Charges above the UCR amount can be balance-billed to the insured. It is not an open-ended promise to pay any billed amount, nor a fixed surgical schedule.

**690. A**

Sickness definitions typically require the illness to first manifest, meaning first show symptoms or be diagnosed, while coverage is in force. A condition already evident before the effective date fails that definition, which is how policies distinguish new illness from pre-existing conditions. Accident coverage is separate and applies to unforeseen bodily injury, not disease.

**691. B**

Under standard coordination of benefits rules, the plan that covers the patient as an employee (or member) pays before a plan that covers the same person as a dependent. Her employer's plan is therefore primary, and the husband's plan may pick up remaining eligible charges as secondary. See the NAIC-model coordination of benefits rules.

**692. C**

The birthday rule makes primary the plan of the parent whose birthday falls earlier in the calendar year, comparing only month and day, never the year of birth. Although the father is older, the mother's January birthday precedes his March birthday, so her plan pays first. See the NAIC-model coordination of benefits rules.

**693. D**

When parents are divorced or separated and no court decree fixes responsibility, the custodial parent's plan pays first, followed by the custodial parent's spouse's plan, and then the non-custodial parent's plan. A decree naming a responsible parent, if the plan knows of it, would override this order, and the birthday rule applies instead in joint-custody situations. See the NAIC-model coordination of benefits rules.

**694. A**

Subrogation substitutes the insurer into the insured's legal rights against a negligent third party after the insurer pays the claim. The insurer can recover what it paid from the responsible party, which keeps the insured from being paid twice for the same loss and helps hold down premiums for all policyholders.

**695. B**

Precertification, a form of prospective review, requires the plan's approval before elective services such as scheduled hospital admissions. Concurrent review takes place during the course of treatment, monitoring the ongoing stay so care continues only as long as medically necessary. Retrospective review, by contrast, examines care after it has been delivered.

**696. C**

When a person 65 or older has group health coverage based on current employment and the employer has 20 or more employees, the group health plan pays first and Medicare is the secondary payer. If the employer had fewer than 20 employees, the order would reverse and Medicare would pay first. See medicare.gov.

**697. B**

Property insurance protects physical property (buildings, personal property, equipment) against damage or loss from covered perils such as fire, theft, or natural disasters.

**698. C**

Casualty insurance (liability insurance) covers the insured's legal liability for injuries to others or damage to their property. It protects against claims and lawsuits from third parties.

**699. D**

Actual cash value (ACV) is the value of property at the time of loss, calculated as replacement cost minus depreciation. It reflects what the property was worth just before it was damaged or destroyed.

**700. A**

Replacement cost coverage pays to replace or repair damaged property with new items of similar kind and quality, without deducting for depreciation. It provides more complete recovery than ACV coverage.

**701. B**

A peril is a specific cause of loss or event that may result in damage and trigger an insurance claim, such as fire, theft, windstorm, or vandalism.

**702. C**

A named perils (or specified perils) policy only covers losses caused by perils specifically listed in the policy. If a peril isn't named, it isn't covered.

**703. D**

An open perils (all-risk) policy covers all causes of loss except those specifically excluded in the policy. It provides broader coverage than named perils policies.

**704. A**

Indemnification is the principle of restoring the insured to the same financial position they were in before the loss occurred - no better and no worse. It prevents profit from insurance claims.

**705. B**

In property insurance, coinsurance requires the policyholder to insure property to at least a specified percentage (typically 80%) of its value. Failure to meet this requirement can result in reduced claim payments.

**706. C**

If the property owner fails to insure to the required percentage, they become a coinsurer and may receive only a proportional payment for claims (based on the ratio of coverage to required coverage).

**707. D**

An endorsement (or rider) is a written document attached to a policy that modifies the original contract by adding, deleting, or changing coverage or conditions.

**708. A**

A floater is insurance that covers movable property regardless of its location. It provides coverage for items like jewelry, art, or equipment that may be transported or used at various locations.

**709. B**

Ordinance or law coverage pays for the increased cost to repair or rebuild a structure to comply with current building codes and ordinances that weren't in effect when the building was originally constructed.

**710. C**

Bodily injury liability coverage protects the insured when legally responsible for injuring another person. It pays for medical expenses, lost wages, pain and suffering, and legal defense costs.

**711. D**

Property damage liability coverage protects the insured when legally responsible for damaging another person's property, such as their vehicle, home, or belongings.

**712. A**

Personal liability coverage in a homeowners policy protects the insured against claims alleging they caused bodily injury or property damage to others, covering legal defense costs and damages up to policy limits.

**713. B**

An umbrella policy provides excess liability coverage above the limits of underlying primary policies (auto, homeowners). It also may cover claims excluded by underlying policies.

**714. C**

Negligence is the failure to exercise the degree of care that a reasonable person would exercise under similar circumstances, resulting in harm or damage to another person or property.

**715. D**

To prove negligence, a plaintiff must establish four elements: (1) the defendant had a duty of care, (2) the defendant breached that duty, (3) the breach was the proximate cause of injury, and (4) actual damages resulted.

**716. A**

Auto liability coverage protects you financially when you're legally responsible for injuring others or damaging their property in an accident. It pays their medical bills, property damage, and legal defense costs.

**717. B**

Collision coverage pays for damage to your own vehicle when it collides with another vehicle or object (like a tree or guardrail), regardless of who is at fault.

**718. C**

Comprehensive coverage pays for damage to your vehicle from causes other than collision, such as theft, vandalism, fire, natural disasters, hitting an animal, or falling objects.

**719. D**

Uninsured motorist coverage protects you if you're injured by a driver who has no liability insurance or in a hit-and-run accident. It covers your medical expenses and damages.

**720. A**

Underinsured motorist coverage pays the difference when the at-fault driver's liability limits are not enough to cover your damages. It fills the gap between their coverage and your actual losses.

**721. B**

Medical payments coverage pays for medical expenses for you and your passengers injured in an auto accident, regardless of who caused the accident. It's no-fault coverage with relatively low limits.

**722. C**

Personal injury protection (PIP) is no-fault coverage that pays for medical expenses, lost wages, and other costs for you and passengers regardless of who caused the accident. It's required in no-fault states.

**723. D**

In a no-fault state each driver's own policy pays personal injury protection benefits such as medical expenses and lost wages regardless of who caused the accident, which limits lawsuits and speeds payment. In most no-fault states vehicle property damage is still handled on a fault basis or through the owner's own collision coverage; Michigan is an exception, limiting recovery for vehicle damage to a small capped mini-tort claim. No-fault does not mean the at-fault driver's insurer pays everyone's losses in full, it restricts rather than expands the right to sue, and it applies to injury benefits, not to a reversal where vehicle damage is no-fault and injuries are fault-based.

**724. A**

A standard homeowners policy includes: Coverage A (dwelling), Coverage B (other structures), Coverage C (personal property), Coverage D (loss of use), Coverage E (personal liability), and Coverage F (medical payments).

**725. B**

Dwelling coverage (Coverage A) protects the physical structure of your home and any structures attached to it, such as an attached garage or deck, against covered perils.

**726. C**

Other structures coverage (Coverage B) protects structures on your property that are not attached to the dwelling, such as detached garages, fences, storage sheds, and pools.

**727. D**

Personal property coverage (Coverage C) protects your personal belongings, including furniture, clothing, and electronics, whether at home or temporarily away from home (like while traveling).

**728. A**

Loss of use coverage (Coverage D) pays for additional living expenses like hotel stays and restaurant meals if your home becomes uninhabitable due to a covered loss.

**729. B**

HO-3 is the most common homeowners policy. It provides open-peril (all-risk) coverage for the dwelling and named-peril coverage for personal property.

**730. C**

HO-4 is renter's insurance. It covers the tenant's personal property and liability but not the building structure (which is the landlord's responsibility).

**731. D**

HO-6 is a condominium owners policy. It covers the condo owner's personal property, improvements made to the unit, and liability. The condo association typically insures the building structure.

**732. A**

A Business Owners Policy (BOP) is a package policy designed for small businesses that combines commercial property coverage, business liability, and business interruption coverage.

**733. B**

Business interruption insurance covers lost income and continuing operating expenses when a business must suspend operations due to a covered property loss, such as a fire.

**734. C**

Commercial general liability (CGL) insurance protects businesses against third-party claims of bodily injury, property damage, personal injury (like slander), and advertising injury.

**735. D**

Professional liability insurance (errors and omissions or malpractice insurance) covers claims arising from professional mistakes, negligent acts, or failure to perform professional duties.

**736. A**

Workers compensation insurance provides benefits to employees who are injured or become ill as a result of their job. It covers medical expenses, lost wages, and rehabilitation costs regardless of fault.

**737. B**

Workers compensation insurance is mandatory in most states for businesses with employees. Requirements vary by state regarding exemptions, coverage limits, and employer size thresholds.

**738. C**

The insured's first duty after a loss is to promptly notify the insurance company. Delay in notification can potentially affect the claim if it prejudices the insurer's ability to investigate.

**739. D**

A proof of loss is a formal, sworn statement submitted by the insured to the insurance company documenting the facts of the loss, the amount claimed, and other relevant information.

**740. A**

A claims adjuster investigates insurance claims to determine coverage, evaluate the extent of damage or loss, and recommend appropriate claim payment amounts based on policy terms.

**741. B**

Salvage is damaged property the insurer takes over after paying a claim, and it may then sell to reduce the net cost of the loss. It is not limited to total losses; property forms let the insurer take all or part of damaged property at an agreed or appraised value. Salvage concerns the property itself, whereas subrogation concerns recovering money from the party responsible for the loss.

**742. C**

Subrogation is the insurer's right, after paying a claim, to pursue recovery of the payment from the third party who caused the loss. This prevents the insured from collecting twice.

**743. D**

Insurance fraud is intentional deception committed by an applicant, policyholder, or claimant for the purpose of obtaining insurance benefits to which they are not entitled.

**744. A**

Arson is the intentional and malicious burning of property. Insurance claims for fire losses caused by arson committed by the insured are denied and can result in criminal prosecution.

**745. B**

The duty to defend is the insurer's obligation to provide legal defense for the insured against covered claims, even if the claims are groundless. This is separate from the duty to pay damages.

**746. C**

Bad faith occurs when an insurer unreasonably denies or delays payment of legitimate claims, fails to investigate properly, or otherwise acts unfairly toward the insured. It can result in significant penalties.

**747. C**

Builders risk insurance (course of construction insurance) covers buildings under construction against physical damage or loss from covered perils like fire, vandalism, or weather.

**748. D**

Inland marine insurance covers goods in transit over land, movable property, and items that may be at various locations. Despite its name, it has little to do with water transportation.

**749. A**

Ocean marine insurance covers ships (hull coverage), cargo being transported by water, freight charges, and liability for damage to others' property or vessels.

**750. B**

D&O liability insurance protects directors and officers of a company from personal liability when sued for alleged wrongful acts in managing the company, such as breach of fiduciary duty.

**751. C**

EPL insurance protects employers against claims by employees alleging wrongful employment practices such as discrimination, sexual harassment, wrongful termination, or retaliation.

**752. D**

Cyber liability insurance covers losses from data breaches, cyberattacks, network damage, and related liabilities including notification costs, credit monitoring, and legal expenses.

**753. A**

Garage liability insurance provides liability coverage for auto dealerships, repair shops, service stations, and other businesses that work with vehicles, covering both premises and auto liability exposures.

**754. B**

Products liability insurance covers claims arising from bodily injury or property damage caused by products that a business manufactures, sells, or distributes.

**755. C**

Completed operations coverage protects contractors and others against liability for bodily injury or property damage arising from work after it has been completed and handed over to the customer.

**756. D**

Bailee coverage applies to property of others in the insured's care, custody, or control, such as customer goods held by a repair shop or dry cleaner. Bailee legal liability forms pay only when the bailee is legally liable, while bailees customers forms pay for damage to customers' property whether or not the bailee is legally liable. The insured's own property is covered under its ordinary property insurance instead.

**757. A**

A surety bond is a three-party agreement where the surety (typically an insurer) guarantees to the obligee that the principal will fulfill a contractual or legal obligation.

**758. B**

A fidelity bond (employee dishonesty coverage) protects a business against losses caused by dishonest acts of employees, such as theft, forgery, or embezzlement.

**759. C**

The NFIP is a federal program administered by FEMA that provides flood insurance to property owners in participating communities, where private flood coverage has historically been limited or unavailable.

**760. D**

Standard homeowners and business property policies specifically exclude flood damage. A separate flood insurance policy, typically through the NFIP or private insurers, is required for flood coverage.

**761. A**

Standard homeowners policies exclude earthquake damage. Coverage requires purchasing a separate earthquake policy or adding an earthquake endorsement to the existing policy.

**762. B**

The attractive nuisance doctrine holds property owners liable for injuries to children who are attracted onto the property by dangerous conditions (like swimming pools or trampolines) that the owner should protect against.

**763. C**

Vicarious liability holds one party legally responsible for the actions of another party, such as an employer being liable for the negligent acts of employees performed within the scope of employment.

**764. D**

Strict liability (absolute liability) holds a party responsible for damages regardless of negligence or fault. It typically applies to inherently dangerous activities or defective products.

**765. A**

Joint and several liability means each defendant can be held responsible for the full amount of damages, allowing the plaintiff to collect the entire judgment from any defendant, regardless of their individual share of fault.

**766. B**

Comparative negligence is a legal principle that reduces a plaintiff's recovery by their percentage of fault in causing the injury. In pure comparative negligence, even a 99% at-fault plaintiff can recover 1%.

**767. C**

Contributory negligence is a strict legal defense that completely bars a plaintiff from recovering damages if they were even partially at fault for their own injury. Only a few states still use this doctrine.

**768. D**

The aggregate limit is the maximum total amount an insurer will pay for all claims during a policy period. Once exhausted, no further claims are covered until the policy renews.

**769. A**

The per occurrence limit is the maximum amount an insurer will pay for all claims arising from a single covered event or occurrence, regardless of the number of claimants.

**770. B**

A claims-made policy responds to claims first made against the insured during the policy period, provided the injury or damage occurred on or after the policy's retroactive date. An occurrence policy instead responds to injury or damage that happens during the policy period, no matter when the claim is reported. Extended reporting period endorsements, often called tail coverage, protect against claims reported after a claims-made policy ends.

**771. C**

Occurrence coverage applies when the covered incident happens during the policy period, regardless of when the claim is filed. It provides ongoing protection even after the policy expires.

**772. D**

A tail (extended reporting period) endorsement allows claims to be reported after a claims-made policy ends, for incidents that occurred during the policy period but are reported later.

**773. A**

An SR-22 is a certificate of financial responsibility that proves a driver carries at least the minimum required auto liability insurance. It's typically required after serious violations like DUI or driving without insurance.

**774. B**

Gap insurance covers the difference between a vehicle's actual cash value (what insurance pays) and the remaining loan or lease balance if the car is totaled or stolen while the owner still owes more than it's worth.

**775. C**

Rental reimbursement coverage pays for a rental car while your vehicle is being repaired after a covered loss, up to a daily and total limit specified in the policy.

**776. D**

Towing and labor coverage pays for towing services and minor roadside assistance labor (like changing a flat tire or jump-starting a battery) when your vehicle is disabled.

**777. A**

Blanket coverage provides a single sum of insurance that applies across multiple properties or items rather than specifying separate limits for each. It offers flexibility in covering shifting values.

**778. B**

Valued policy laws in some states require insurers to pay the full face amount of a property insurance policy in case of total loss, regardless of the actual cash value at the time of loss.

**779. C**

Extra expense coverage pays for additional costs incurred to continue business operations after a covered loss, such as renting temporary facilities or equipment while repairs are made.

**780. C**

Garagekeepers coverage insures damage to customers' autos in the care, custody, and control of a garage business - an exposure that garage liability and standard property forms exclude. Garage liability instead covers the business's own operations and autos. Customers' own policies might respond, but the shop buys garagekeepers so claims can be paid without pushing customers onto their own insurance.

**781. A**

Civil authority coverage extends business income and extra expense protection when a government order - not damage to the insured's own property - bars access to the premises because of covered physical damage nearby. Coverage typically begins after a short waiting period following the order and lasts for a limited number of weeks stated in the form.

**782. B**

E&O insurance is professional liability coverage protecting against claims of negligence, errors, or omissions in providing professional services. It's commonly carried by insurance agents, lawyers, and consultants.

**783. B**

Professional liability policies often require the insured's consent before settling, protecting professional reputations. The trade-off is the hammer clause: if the insured rejects a settlement the claimant would have accepted, the insurer's exposure can be capped at that settlement amount plus defense costs to that date - leaving later defense costs and any larger judgment to the insured. Some forms soften the cap with percentage sharing.

**784. C**

With defense inside the limits - a 'wasting' or 'burning' limit - every dollar spent on attorneys and experts reduces what remains for settlements or judgments. Standard CGL policies instead pay defense costs in addition to their limits. Professionals buying wasting policies should size limits with defense costs in mind, since those costs are often substantial in E&O and malpractice claims.

**785. A**

Fiduciary liability insurance protects plan administrators and other fiduciaries from personal liability for breaches of their duties in managing employee benefit plans covered by ERISA.

**786. A**

Under a duty-to-defend policy the insurer takes over the defense itself. Many D&O and some professional liability forms are instead written on a reimbursement basis: the insured selects counsel - often subject to insurer consent - manages the defense, and the insurer indemnifies covered defense costs and loss as they are incurred or when the claim resolves.

**787. C**

Contingent business interruption covers income loss when the insured's operations are affected by physical damage to a key supplier's or customer's property, even when the insured's property is undamaged.

**788. D**

Products-completed operations hazard refers to liability for bodily injury or property damage arising from the insured's products after they leave the insured's control or from completed work away from the premises.

**789. A**

Premises and operations coverage is part of general liability insurance that covers bodily injury or property damage occurring on the insured's premises or arising from the insured's ongoing business operations.

**790. B**

Personal and advertising injury coverage in CGL policies covers offenses including false arrest, libel, slander, invasion of privacy, and copyright infringement committed in the course of advertising.

**791. C**

When an umbrella responds to a loss its underlying policies do not cover at all, the insured first pays the self-insured retention - commonly a few hundred to a few thousand dollars. When the umbrella instead sits above an underlying policy that does cover the loss, the underlying policy's limit serves as the attachment point and no retention applies.

**792. D**

Excess liability insurance provides additional limits above an underlying policy but follows the same terms and conditions. Unlike umbrella policies, it typically doesn't broaden coverage.

**793. A**

Hired and non-owned auto coverage provides liability protection when employees use rented vehicles (hired) or their personal vehicles (non-owned) for business purposes.

**794. B**

Motor carrier insurance is specialized commercial auto coverage for trucking companies and other businesses that transport goods or passengers for hire, meeting DOT and state requirements.

**795. C**

Cargo insurance covers goods while being transported from one location to another against loss or damage during transit. It can cover various modes including truck, rail, air, and ocean shipping.

**796. B**

A bailees customers form pays for loss or damage to customers' property in the insured's care, custody, or control whether or not the bailee is legally liable, which is what protects the customer relationship. A bailee legal liability form responds only when the insured is actually legally liable, so it would not pay here. A commercial property form can cover personal property of others in the insured's care, but only for a covered cause of loss at the described premises, so it would not respond to damage the cleaner caused during processing.

**797. A**

Pollution liability insurance covers cleanup costs and third-party liability for bodily injury and property damage arising from pollution incidents, which are typically excluded from standard liability policies.

**798. B**

Contractual liability coverage protects the insured when they assume another party's liability through a contract, such as a hold harmless or indemnification agreement in a lease or service contract.

**799. B**

Negligence per se treats the violation of a safety statute meant to protect people like the plaintiff as establishing the breach of duty, without asking what a 'reasonable person' would have done. The plaintiff must still prove the violation caused the injury. It differs from strict liability, which imposes responsibility without any showing of negligence at all.

**800. A**

Res ipsa loquitur - 'the thing speaks for itself' - lets a plaintiff establish an inference of negligence without direct proof when the accident is of a kind that ordinarily involves negligence, the instrumentality was in the defendant's exclusive control, and the plaintiff did not contribute to the event. The defendant can still rebut the inference with evidence of due care.

**801. D**

Compensatory damages divide into special damages - measurable economic losses such as medical bills and lost wages - and general damages, which compensate non-economic harm such as pain and suffering, disfigurement, and loss of consortium. Punitive damages are different altogether: they punish egregious conduct rather than compensate, and some states do not allow them to be insured.

**802. C**

Under a 51% bar, a plaintiff recovers only if her share of fault does not exceed 50% - at 60% she recovers nothing. Had she been 40% at fault she would have recovered $60,000, her damages reduced by her own percentage. In a pure comparative negligence state, a 60%-at-fault plaintiff would still recover $40,000.

**803. C**

Assumption of risk is a defense arguing the plaintiff cannot recover because they voluntarily exposed themselves to a known danger. It can be express (signed waiver) or implied (participating in risky activities).

**804. D**

Punitive damages are awarded on top of compensatory damages to punish particularly egregious, willful, or malicious conduct and to deter similar behavior. Compensatory damages reimburse the claimant's actual loss, criminal penalties are imposed by the state rather than awarded to a plaintiff, and court costs and attorney fees are litigation expenses rather than a punishment. Whether punitive damages can be insured is governed by each state's public policy, so it varies from state to state.

**805. A**

The statute of limitations sets the maximum time after an event within which a lawsuit can be filed. This varies by state and type of claim, affecting how long potential liability exposure exists.

**806. B**

Most states let employers buy workers compensation from private insurers or qualify to self-insure. A few monopolistic states - North Dakota, Ohio, Washington, and Wyoming - require coverage to be bought from an exclusive state fund.

Because those funds generally do not include employer's liability coverage, employers there often add 'stop gap' liability coverage to another policy.

**807. C**

The exclusive remedy doctrine means workers' compensation is typically the only remedy for employees injured on the job, generally preventing them from suing their employer for negligence.

**808. D**

Experience modification (mod) compares an employer's actual losses to expected losses for their industry. A mod above 1.0 increases premiums; below 1.0 decreases them, incentivizing workplace safety.

**809. A**

Retrospective rating plans adjust the final premium after the policy period based on actual losses. Good loss experience results in a return premium; poor experience means additional premium owed.

**810. B**

NCCI (National Council on Compensation Insurance) is a rating organization that develops workers' compensation classification codes, experience rating, and loss costs used by insurers in most states.

**811. C**

A maintenance bond covers the period after completion, guaranteeing the project owner that defects in workmanship or materials appearing within the bond's term - often a year or two - will be corrected. Bid bonds guarantee a bidder will contract at its bid price, payment bonds guarantee subcontractors and suppliers are paid, and fidelity bonds cover employee dishonesty, not construction quality.

**812. C**

Judicial bonds are required in court proceedings to protect a party from loss: an appeal bond secures payment of the original judgment if the appeal fails, an attachment bond protects a defendant whose property is wrongly seized, and fiduciary bonds - guardianship or executor bonds - guarantee faithful management of another person's assets. Contract bonds relate to construction obligations; license bonds to regulatory compliance.

**813. A**

A performance bond guarantees the contractor will complete the project according to contract specifications. If they fail, the surety either finds another contractor or pays the project owner for damages.

**814. B**

A payment bond guarantees that the contractor will pay all subcontractors, laborers, and material suppliers. It protects these parties when they cannot place liens on public projects.

**815. C**

A bid bond guarantees that if the bidder is awarded the contract it will enter into that contract and furnish the required performance and payment bonds. If the winning bidder backs out, the surety pays the owner the difference between that bid and the next acceptable bid, up to the bond's penal sum. Guaranteeing payment to subcontractors and suppliers is the job of a payment bond, and guaranteeing completion of the work is the job of a performance bond.

**816. A**

The duties-after-loss conditions of property policies commonly let the insurer require an examination under oath while investigating a claim. It is contractual and happens before any lawsuit; unreasonably refusing to sit for one can jeopardize the claim. It differs from a deposition, which is part of litigation, and from appraisal, which resolves disputes over the amount of a covered loss.

**817. A**

Coverage A generally applies to the dwelling. Other homeowners coverage parts apply to other structures, personal property, liability, or loss of use depending on the policy form.

**818. B**

Coverage B is commonly used for other structures on the residence premises, such as a detached garage, shed, or fence, subject to policy conditions and exclusions.

**819. C**

Coverage C generally applies to personal property. Candidates should remember that special limits and exclusions may apply to certain categories of property.

**820. D**

Coverage D is commonly associated with loss of use, including additional living expense when a covered loss makes the residence unfit to live in.

**821. A**

Coverage E is commonly the personal liability coverage in a homeowners policy. It may respond when an insured is legally liable for covered bodily injury or property damage.

**822. B**

Coverage F is usually medical payments to others. It can pay limited medical expenses for others injured under covered circumstances without first proving negligence.

**823. C**

Flood from rising water is commonly excluded under standard homeowners forms. Separate flood coverage may be needed depending on the risk and location.

**824. D**

Scheduled personal property coverage is often used for valuable items such as jewelry, fine arts, or collectibles that need specific coverage beyond standard policy limits.

**825. A**

Replacement cost coverage generally pays the cost to replace damaged property with comparable new property, subject to policy conditions, limits, and deductibles.

**826. B**

Actual cash value is commonly explained as replacement cost minus depreciation. Exact policy language can vary, but depreciation is the key exam concept.

**827. C**

Bodily injury liability coverage can pay for covered injuries to others when the insured is legally responsible, subject to the policy limit and conditions.

**828. D**

Property damage liability may pay for covered damage the insured legally causes to another person's property, such as another vehicle, fence, or building.

**829. A**

Collision coverage generally applies to physical damage to a covered auto caused by collision or overturn, subject to policy terms and deductible.

**830. B**

Comprehensive, often called other-than-collision coverage, commonly applies to covered losses such as theft, fire, vandalism, falling objects, and certain weather events.

**831. C**

Uninsured motorist coverage may protect insureds when they are injured by a driver who does not have applicable liability insurance, subject to policy and state requirements.

**832. D**

Underinsured motorist coverage is designed for situations where the responsible driver has liability insurance but the limits are insufficient for the covered loss.

**833. A**

Medical payments coverage generally pays covered medical expenses for insured persons after an auto accident, regardless of fault, subject to limits and policy terms.

**834. B**

A split limit usually lists bodily injury per person, bodily injury per accident, and property damage per accident in that order.

**835. C**

Physical damage coverages such as collision and comprehensive often use deductibles. Liability coverages generally do not use deductibles in standard personal auto policies.

**836. D**

A named non-owner policy may provide personal auto liability coverage for a person who does not own a vehicle but regularly drives borrowed or rented vehicles.

**837. A**

Liability insurance is designed to respond when the insured is legally responsible for covered bodily injury, property damage, or certain other covered claims.

**838. B**

The duty to defend generally requires the insurer to provide a legal defense for claims covered or potentially covered by the policy, subject to policy language.

**839. C**

Proximate cause is the legal cause closely related enough to the injury to support liability. It is a core concept in negligence and liability claims.

**840. D**

Negligence usually requires duty, breach of duty, causation, and damages. A breach of duty is one of the key elements.

**841. A**

Compensatory damages are designed to compensate for actual covered loss, such as medical bills, property damage, lost wages, or pain and suffering.

**842. B**

Punitive damages are meant to punish and deter especially wrongful conduct. Whether insurance can cover them depends on policy language and applicable law.

**843. C**

An aggregate limit is the total amount a policy will pay for specified covered claims during a policy period, subject to the policy wording.

**844. D**

An occurrence limit is the maximum amount payable for one covered occurrence, subject to other limits such as aggregate limits.

**845. A**

An umbrella policy can provide additional liability limits above required underlying policies and may provide broader liability coverage in some situations.

**846. B**

A guest injury may create a liability claim if the insured is alleged to be legally responsible. Damage to the insured's own property is usually a first-party property issue.

**847. C**

Commercial property insurance generally covers business buildings, business personal property, and related property exposures against covered causes of loss.

**848. D**

Business personal property generally includes covered business-owned contents such as inventory, furniture, equipment, and supplies at described premises.

**849. A**

Business income coverage can help replace lost income and continuing expenses when operations are suspended due to covered physical loss or damage.

**850. B**

Extra expense coverage can pay necessary costs incurred to continue operations or reduce the business interruption after a covered property loss.

**851. C**

Builders risk coverage is designed for buildings or structures while they are being constructed, renovated, or repaired, subject to policy terms.

**852. D**

The causes of loss form identifies covered causes of loss and exclusions for commercial property coverage. It is central to determining whether property damage is covered.

**853. A**

Vacancy can increase risk of certain losses. Commercial property policies often include vacancy conditions that may limit or restrict coverage after a specified vacancy period.

**854. B**

A coinsurance clause encourages adequate insurance-to-value. If the insured carries too little insurance, a coinsurance penalty may reduce a partial-loss payment.

**855. C**

CGL coverage generally addresses common business liability exposures, including covered bodily injury, property damage, and personal and advertising injury claims.

**856. D**

Coverage A of a CGL policy generally covers bodily injury and property damage liability, subject to definitions, exclusions, and conditions.

**857. A**

Coverage B of a CGL policy generally applies to personal and advertising injury liability, such as certain covered offenses listed in the policy.

**858. B**

Coverage C generally provides limited medical payments for certain injuries on or near the insured premises or because of the insured's operations, regardless of fault.

**859. C**

Products-completed operations coverage can apply to covered liability arising from the insured's products or completed work after the product or work has left the insured's control.

**860. D**

Premises and operations coverage addresses covered liability arising from the insured's location or ongoing operations, subject to policy exclusions and conditions.

**861. A**

Employee work-related injuries are generally addressed by workers compensation, not standard CGL bodily injury coverage.

**862. B**

Business risk exclusions limit coverage for certain damage to the insured's own work or product. CGL is primarily liability coverage, not a guarantee of work quality.

**863. C**

Workers compensation provides statutory benefits for covered work-related employee injuries or occupational diseases, typically without requiring the employee to prove employer negligence.

**864. D**

Employer's liability coverage can protect against certain employee injury-related lawsuits that fall outside standard workers compensation benefits, subject to policy limits and exclusions.

**865. A**

Workers compensation is generally a no-fault system for covered workplace injuries. State laws and benefit details vary, but no-fault benefits are a core concept.

**866. B**

Workers compensation premiums commonly consider payroll, job classification, rates, and experience modification factors where applicable.

**867. C**

An experience modification factor adjusts premium based on an employer's loss experience compared with expected losses for similar businesses.

**868. D**

Workers compensation commonly includes medical benefits for covered work-related injuries and may also include disability, rehabilitation, or death benefits depending on the law.

**869. A**

Inland marine coverage is often used for movable property, property in transit, contractors equipment, fine arts, and other specialized property exposures.

**870. B**

A contractors equipment floater can insure mobile equipment and tools used at job sites, in transit, or at temporary locations, subject to policy terms.

**871. C**

Accounts receivable coverage can help when records of amounts owed to the insured are damaged by a covered loss, making collection difficult or impossible.

**872. D**

Valuable papers coverage can pay costs to research, replace, or restore valuable documents and records after covered damage or loss.

**873. A**

A transportation floater is an inland marine form that can cover property while it is in transit, subject to policy conditions.

**874. B**

Commercial crime coverage can protect against certain theft-related losses, including employee theft, forgery, or money and securities losses depending on the form.

**875. C**

Employee theft coverage applies to covered dishonest acts by employees, such as stealing money, securities, or other property, subject to policy definitions and limits.

**876. D**

A surety bond involves the principal who must perform, the obligee who requires the bond, and the surety that guarantees the principal's obligation.

**877. A**

A performance bond guarantees that the principal will complete work according to contract terms, protecting the obligee if the principal fails to perform.

**878. B**

Fidelity bonds are used to protect against certain dishonest acts by employees or other covered persons, depending on the bond or coverage form.

**879. C**

An appraisal condition is commonly used when the insurer and insured disagree about the amount of a covered property loss, not whether coverage exists.

**880. D**

A liberalization condition can automatically extend certain broadened coverage changes to existing policies when conditions in the policy are met.

**881. A**

Concealment, misrepresentation, or fraud involving material facts can affect coverage rights under policy conditions and applicable law.

**882. B**

A deductible is the portion of a covered loss the insured is responsible for before insurance payment applies, subject to policy terms.

**883. C**

Normal wear and tear, deterioration, and maintenance-related problems are commonly excluded because insurance is intended for fortuitous losses, not ordinary upkeep.

**884. D**

Policies commonly require the insured to provide prompt notice, protect property from further damage, cooperate with the insurer, and submit requested documentation.

**885. A**

Other insurance provisions explain how a loss is shared or coordinated when multiple policies may apply to the same covered claim.

**886. B**

A pair or set condition addresses how payment is handled when only part of a matched pair or set is damaged, subject to policy wording.

**887. C**

The principle of indemnity means insurance is intended to restore the insured after a covered loss, not create a profit from the claim.

**888. D**

A peril is the cause of loss, such as fire, theft, windstorm, or collision. A hazard is a condition that increases the chance of loss.

**889. A**

A hazard is a condition that increases the probability or severity of a loss. Hazards may be physical, moral, or morale hazards.

**890. B**

A morale hazard is carelessness or indifference to loss because insurance exists. Intentional misconduct would be a moral hazard.

**891. C**

A moral hazard involves dishonest or intentional behavior that increases the chance of loss, such as deliberately causing a loss for financial gain.

**892. D**

Commercial auto coverage addresses business vehicle liability and physical damage needs, depending on the selected forms and symbols.

**893. A**

Covered auto symbols indicate which types of autos apply to each coverage, such as owned, hired, or nonowned autos.

**894. B**

Nonowned auto liability can address the employer's liability exposure when employees use personally owned vehicles for business purposes.

**895. C**

Hired auto coverage applies to autos the business leases, hires, rents, or borrows, subject to the policy terms.

**896. D**

Hired auto coverage addresses rented or borrowed autos, while nonowned auto coverage addresses vehicles the business does not own, such as employee vehicles used for business.

**897. A**

Commercial auto physical damage coverage helps pay for damage to covered vehicles, depending on selected causes of loss and deductibles.

**898. B**

Auto liability coverage addresses covered legal liability arising from auto accidents. It does not pay for damage to the insured's own autos, employee injuries, or losses caused by uninsured drivers, which require physical damage, workers compensation, or uninsured motorists coverage.

**899. A**

Liability coverage protects against covered third-party claims. Damage to the insured's own vehicle usually requires physical damage coverage.

**900. C**

A business using vehicles in operations, such as delivery vans, usually has commercial auto exposures.

**901. D**

The declarations page identifies key policy choices, but coverage still depends on the full policy terms, exclusions, and endorsements.

**902. B**

A BOP is designed to package property and liability coverages for many eligible small businesses.

**903. C**

A BOP can be convenient for eligible small businesses because it packages common coverages, but exclusions and optional endorsements still matter.

**904. D**

Business personal property coverage usually applies to covered contents used in the business, subject to limits and exclusions.

**905. A**

Business income coverage may help replace lost income during a covered suspension caused by a covered cause of loss.

**906. B**

BOP liability coverage is intended for common third-party liability claims, subject to exclusions and conditions.

**907. C**

BOP eligibility is often limited by business type, size, revenue, premises, and risk characteristics. Higher-hazard operations may require different coverage.

**908. D**

Workers compensation is usually written separately and is not replaced by a BOP.

**909. A**

The BOP property section addresses covered business property, such as buildings and contents, subject to policy terms.

**910. B**

Endorsements change the policy. They may add, limit, or clarify coverage depending on the wording.

**911. C**

Exclusions identify losses or exposures not covered by the policy. A business may need endorsements or separate policies for those exposures.

**912. D**

Farm policies are designed for agricultural property and liability exposures that may not fit standard homeowners or commercial forms.

**913. A**

Farm risks may include a dwelling, personal property, farm buildings, machinery, livestock, and liability exposures.

**914. B**

Farm personal property coverage can address covered farm equipment, machinery, tools, supplies, and similar property, depending on the policy.

**915. C**

Livestock coverage can vary significantly. Covered causes, limits, valuation, and exclusions must be reviewed closely.

**916. D**

Farm liability coverage protects against covered third-party liability claims related to farm operations, subject to exclusions.

**917. A**

A tractor used in farm operations is a farm property exposure that may need specific coverage.

**918. B**

Farm vehicles and mobile equipment may require careful classification and separate or endorsed coverage.

**919. C**

Public events can create liability exposures beyond ordinary farm operations. Coverage should be reviewed and endorsed if needed.

**920. A**

Equipment breakdown coverage addresses covered breakdown events involving certain mechanical, electrical, or pressure equipment.

**921. D**

Equipment breakdown coverage focuses on covered breakdowns of equipment, not general liability, theft of autos, or advertising injury.

**922. B**

Spoilage coverage can help with perishable property damaged because of a covered equipment breakdown, when included.

**923. C**

Standard property coverage may not fully cover mechanical or electrical breakdown exposures. Equipment breakdown fills that gap when properly added.

**924. D**

Expediting expense coverage can help pay reasonable extra costs to make temporary repairs or speed permanent repairs after a covered breakdown.

**925. A**

Boiler and machinery exposures are classic equipment breakdown concerns.

**926. B**

Businesses that depend on mechanical, electrical, or refrigeration equipment often need equipment breakdown review.

**927. C**

Equipment breakdown may address the damaged machinery, while business income or extra expense coverage may address covered downtime if included.

**928. D**

Professional liability, also called errors and omissions coverage in many fields, addresses covered claims arising from professional services.

**929. A**

General liability focuses on bodily injury, property damage, and personal/advertising injury. Professional liability addresses certain professional service errors.

**930. B**

Errors and omissions coverage is a common form of professional liability protection.

**931. C**

An agent E&O policy may address covered claims alleging professional mistakes, such as failure to procure requested coverage.

**932. D**

Professional liability is often written on a claims-made basis, meaning timing of the claim and reporting requirements are critical.

**933. A**

A retroactive date limits coverage for acts occurring before that date. Claims-made policies require careful attention to dates and reporting conditions.

**934. B**

An extended reporting period allows reporting of certain claims after policy termination for acts that occurred during the covered period, subject to terms.

**935. C**

Professionals who provide specialized services or advice can face professional liability exposure.

**936. D**

Most policies require prompt notice of loss so the insurer can investigate and handle the claim.

**937. A**

A proof of loss gives the insurer information about the loss and the amount claimed, when required by the policy.

**938. B**

Policies often require the insured to take reasonable steps to protect property from further damage after a loss.

**939. C**

Subrogation allows the insurer to pursue recovery from a responsible third party after paying a covered claim.

**940. D**

Salvage is property that remains after a loss and may still have value. Claim settlement may account for salvage depending on the policy.

**941. A**

Photos, receipts, inventories, and repair estimates can support the claim and help the insurer evaluate covered damage.

**942. B**

Adjusters investigate facts, review coverage, estimate damages, and help settle claims according to the policy and applicable rules.

**943. C**

A deductible is the insured's share of a covered loss before the policy pays, depending on the policy wording.

**944. D**

An endorsement modifies the insurance contract by changing coverage, limits, exclusions, or conditions.

**945. B**

Construction costs rise, and a limit that was adequate at issue can quietly fall below what rebuilding would cost - inviting a coinsurance penalty. The inflation guard endorsement automatically raises the covered limit by a chosen annual percentage so coverage keeps pace without re-underwriting each year. The premium rises with the limit; deductibles and the valuation basis are unchanged.

**946. B**

Additional insured endorsements extend insured status to another party for certain claims, subject to the endorsement wording.

**947. C**

A waiver of subrogation prevents the insurer from seeking recovery from a specified party, when the endorsement applies.

**948. D**

A loss payable clause can give a lender or other interested party rights to claim payments involving covered property.

**949. A**

An endorsement is part of the policy and can significantly broaden, restrict, or clarify coverage.

**950. B**

Named perils coverage applies only to causes of loss named in the policy or endorsement.

**951. C**

Endorsements are contractual changes and should be read together with the policy.

**952. D**

Damage to a customer's property caused by business operations is a typical commercial general liability exposure, subject to exclusions.

**953. A**

Damage to a building from a covered cause of loss such as windstorm is a property coverage issue.

**954. B**

Workers compensation is designed to address covered employee work-related injuries according to applicable law.

**955. C**

A customer slip-and-fall claim is a premises liability exposure commonly addressed by general liability coverage.

**956. D**

Professional liability is designed for certain financial-loss claims arising from professional services, unlike general liability focused on bodily injury and property damage.

**957. A**

Equipment breakdown and spoilage coverage may address mechanical failure and resulting spoilage if included in the policy.

**958. B**

A rented vehicle creates a hired auto exposure. The business should review both liability and physical damage coverage needs.

**959. C**

Flood is commonly excluded or limited in many property policies and may require separate flood coverage or endorsement.

**960. D**

Commercial property policies often identify covered locations, buildings, and limits. Unlisted or newly acquired locations may have limited coverage.

**961. A**

Contractors often have liability exposures and mobile property exposures. These are commonly handled by different coverage forms.

**962. B**

Claims-made policies can leave reporting gaps after cancellation. An extended reporting period may allow certain later-reported claims to be submitted.

**963. C**

Blanket coverage can apply one limit across multiple covered items or locations, subject to policy terms.

**964. D**

A coinsurance clause can penalize the insured for carrying less insurance than required by the policy formula.

**965. A**

Moral hazard involves behavior or character that increases the chance or size of loss, such as intentionally exaggerating a claim.

**966. B**

Business changes can create new property, liability, auto, or professional exposures. Policies should be reviewed so coverage matches current operations.

**967. C**

A standard (union) mortgage clause creates a separate contract between the insurer and the mortgagee, so acts or neglect of the property owner do not defeat the lender's interest. The insurer pays the lender and then acquires the lender's rights against the borrower. Voiding the policy from inception and forcing the lender into a private suit both describe the weaker open or simple mortgage clause, which gives the mortgagee no independent standing.

**968. D**

The clause is a two-way arrangement: the mortgagee keeps its protection only by paying premium the owner fails to pay, reporting known hazard or ownership changes, and filing proof of loss if the owner does not. Annual inspection duties and deductible responsibility are not policy conditions. Loan-balance insurance requirements come from the loan agreement, not from the insurance contract.

**969. A**

A simple loss payable clause merely directs payment to the lienholder; if the insured's claim fails because of fraud or a breached condition, the loss payee generally collects nothing. The standard mortgage clause is stronger because it survives the insured's misconduct. The loss payee receives no separate policy, and cancellation notice periods are short, not a year.

**970. B**

Appraisal is the contractual mechanism for settling disagreements over the value of property or the amount of loss when coverage itself is not in dispute. Subrogation deals with recovery from a responsible third party, liberalization with automatic policy broadening, and the fraud condition with material misstatements. None of those resolve a pure valuation argument.

**971. C**

The condition provides for an umpire chosen by the two appraisers, and a written agreement by any two of the three parties fixes the amount of loss. The insurer's appraiser has no unilateral power. Regulators do not adjudicate individual valuation disputes this way, and appraisal is intended to avoid immediate litigation rather than trigger a thirty-day suit deadline.

**972. D**

Proof of loss is the insured's own signed and sworn statement of the facts, quantities, and values involved, and the standard condition ties it to a set number of days after the insurer's request. The adjuster's estimate is a company work product, not the insured's proof. Official reports may support a claim but do not replace the sworn statement, and a release signed at settlement is a different document entirely.

**973. A**

Pro rata sharing splits the loss in proportion to each policy's limit, so with $300,000 out of a combined $400,000 the first insurer bears three quarters of the loss. Equal shares would apply only if the limits were equal. The largest limit does not absorb the whole loss, and the insured cannot simply elect one payer, since the condition exists to prevent recovery beyond the actual loss.

**974. B**

Subrogation lets the insurer step into the insured's shoes and pursue the party who caused the loss, so a post-loss release destroys the very right the insurer would inherit. Reporting to authorities, cooperating with inspection, and identifying the responsible party all support subrogation rather than defeat it. Waivers signed before a loss are generally permitted; it is the after-the-loss release that creates the problem.

**975. C**

The abandonment condition simply states that property may not be abandoned to the insurer, preserving the insurer's right to pay only the actual amount of loss. It does not force the insurer to take title at a fifty percent damage threshold. Salvage rights follow a claim payment rather than being surrendered up front, and insurers must still handle claims in good faith

even when the insured is slow.

**976. D**

The defining difference is timing: cancellation terminates a policy before its expiration date, while nonrenewal simply declines to continue coverage past the expiration date. Either party may cancel depending on the policy terms, and advance written notice is generally required for both actions. Neither concept is limited to one line of business.

**977. A**

Property and casualty policies are personal contracts written on the basis of a specific insured's character, financial condition, and loss history, so the assignment condition requires the insurer's written consent. Coverage does not travel with the deed. The mortgagee's interest does not give it authority to approve a transfer, and proof of loss relates to claims rather than ownership changes.

**978. B**

Materiality is the test: the misstatement or silence must be significant enough to have changed whether or on what terms the insurer would have written the risk. Innocent trivial errors do not void a policy. The condition is not limited to written applications, to a thirty-day discovery window, or to loss history alone, since any material fact about the risk can qualify.

**979. C**

Liberalization automatically extends a broadened form to policies already in force without an endorsement or added premium, sparing the insurer from reissuing every contract. The other insurance condition allocates loss among overlapping policies, and appraisal settles valuation disputes. The bailee condition prevents a third party holding the property from profiting from the insured's coverage.

**980. D**

The condition states that the insurance provides no benefit to a party holding the insured's property for a fee, preserving the insurer's right to pursue that bailee through subrogation. It does not create a deductible reimbursement obligation. Coverage is not voided simply because the property was away from the premises, and the insured's insurer owes no defense to an unrelated business.

**981. A**

The pair or set condition lets the insurer either restore the set to its pre-loss condition or pay the reduction in value of the set as a whole, which recognizes that losing one piece hurts more than one eighth of the value. Replacing every undamaged chair is not required. Refusing payment outright ignores that the item was covered, and paying the full personal property limit would far exceed the actual loss.

**982. B**

Property insurance indemnifies actual financial loss, so what matters is whether the claimant would suffer economically when the loss occurs. A person who sold the property before the fire has no interest left and no claim, even though an interest existed when the policy was written. Life insurance is the coverage that keys insurable interest to policy inception instead.

**983. C**

The basic dwelling form starts with fire, lightning, and internal explosion, with extended coverage perils and vandalism available as additions. Open perils coverage is a special form feature, not a basic form feature. Theft, water discharge, falling objects, and weight of ice and snow belong to the broad form or to separate endorsements.

**984. D**

The broad dwelling form adds replacement cost settlement on the dwelling when the insured carries the required percentage of replacement value, while the basic form pays actual cash value. Reversing the two forms misstates the progression from narrow to broad coverage. Replacement cost is not unique to the special form, which mainly changes the perils rather than the valuation rule.

**985. A**

The special form broadens the buildings to open perils, meaning any direct physical loss not excluded, but leaves personal property on the broad form's named perils list. Assuming open perils extends to contents overstates the coverage. Reversing the treatment or keeping both on named perils describes the broad form rather than the special form.

**986. B**

Coverage B applies to appurtenant private structures separated from the dwelling by clear space, such as detached garages, sheds, and fences. Coverage A is limited to the dwelling itself and attached structures. Coverage C insures personal property regardless of where it is stored, and Coverage D addresses lost rents rather than physical structures.

**987. C**

Fair rental value reimburses the landlord for rent lost while the premises are untenantable because of a covered loss, less any expenses that do not continue. Additional living expense is for an insured who actually lives in the dwelling and must

relocate. Personal property and other structures cover physical items rather than lost income.

**988. D**

The basic dwelling form provides fair rental value but leaves additional living expense to be added, while the broad and special forms include it. It is therefore not present in all forms at a uniform percentage. Owner occupants are exactly who the coverage is meant for, and it reimburses the increase in normal living costs rather than continuing debt payments.

**989. A**

The dwelling program is a property-only package, so liability and theft must be added by endorsement, whereas the homeowners package bundles Section II liability and medical payments plus theft coverage. Theft and Section II liability are not automatic under the dwelling program, and valuation depends on which dwelling form is chosen rather than being replacement cost under every form.

**990. B**

The dwelling program was built for one to four family dwellings including non-owner occupied rentals, which fall outside the owner occupancy requirement of the standard homeowners form. Owner occupied homes, condominium units, and tenant contents each have their own dedicated homeowners forms. The absence of the owner as a resident is what pushes the risk to the dwelling program.

**991. C**

The automatic increase endorsement raises the dwelling limit by a stated percentage over the policy term so coverage keeps pace with rising construction costs. Broad theft adds a peril rather than adjusting limits, and the under construction endorsement handles the changing value of a building being built. The liability supplement adds Section II style coverage, which has nothing to do with property limit adequacy.

**992. D**

Standard property forms suspend vandalism and malicious mischief coverage once a building has been vacant beyond the stated number of consecutive days, because an empty building presents a much higher risk. The peril is covered only while the vacancy condition is satisfied. There is no automatic halving of the limit, and advance notice by itself does not restore a suspended peril.

**993. C**

The required amount is 80 percent of $200,000, or $160,000, and the insured carried $120,000, giving a ratio of three quarters that is applied to the loss for a payment of $30,000. Paying the full $40,000 would ignore the coinsurance penalty. The other figures come from misapplying the ratio, such as dividing by the full replacement cost instead of the required amount.

**994. A**

The coinsurance formula reduces the payment when the insured is underinsured, but the stated limit remains an absolute ceiling on any recovery. The insurer never pays replacement cost above the limit, and the amount the insured should have carried is only an input to the formula, not a payable figure. Applying only the deductible would ignore the coinsurance penalty entirely.

**995. B**

Functional replacement cost pays to restore usefulness with contemporary, less costly materials, which suits obsolete or architecturally elaborate construction. Actual cash value would deduct depreciation from the cost of identical materials, which is not the functional replacement approach. Market value reflects land and location factors, and duplicating historic materials is exactly what functional valuation avoids.

**996. D**

Agreed value suspends the coinsurance requirement because the insurer has already accepted the values on which the limit is based, so no penalty is calculated at claim time. It does not change the valuation method from replacement cost to actual cash value. Deductibles still apply, and partial losses are still paid based on the actual damage, not the full limit.

**997. A**

A stated amount sets a ceiling on recovery but does not promise that figure, so the insurer pays the lower of the stated amount or the item's actual value when it is destroyed. That is what separates stated amount from a true valued or agreed amount arrangement, which does guarantee the figure. Neither unlimited replacement cost nor an averaging formula reflects how the provision works.

**998. B**

A combined single limit gives the insurer one pool of money for all bodily injury and property damage arising from one accident, so a severe injury to a single claimant is not restricted by a per person sublimit. Split limits impose exactly those internal caps. The combined limit does not add uninsured motorist coverage, remove deductibles, or reduce what one claimant can receive.

**999. A**

A percentage deductible is applied to the insured value of the building, so two percent of $300,000 produces a $6,000 deduction rather than the flat amount used for ordinary losses. The $1,000 flat deductible applies only to non-wind perils. Applying the two percent to the $50,000 loss instead of to the insured value would yield only $1,000 and badly understate the deductible, which is the most common error candidates make on this calculation.

**1000. C**

A sublimit is a smaller cap carved out of a larger coverage limit for a specific category of property or type of loss, and it is why scheduling valuables is often recommended. Coinsurance penalties result from underinsuring, not from a category cap. An aggregate limit caps all losses across a period, and a deductible is the amount subtracted from a loss rather than a maximum payable.

**1001. D**

Apparent authority arises when the principal's own conduct leads a reasonable third party to believe the producer holds powers the producer does not actually have, and the insurer can be bound as a result. Express authority is what the agency contract states in writing, and implied authority covers the incidental acts needed to carry out express duties. Fiduciary duty concerns the handling of premium funds, not the scope of authority.

**1002. B**

An aleatory contract is one in which the dollars exchanged depend on chance and may be wildly unequal, exactly as a small premium can produce a large claim payment. A unilateral contract means only the insurer makes an enforceable promise, so the choice that makes the insured's promise the enforceable one reverses the parties. Adhesion refers to take-it-or-leave-it wording and conditional refers to duties the insured must meet before payment, neither of which is about unequal value or about when premium can be enforced.

**1003. C**

Because the insured had no opportunity to negotiate the language, courts apply the rule that ambiguities are construed against the party that wrote them, which is the insurer. Resolving doubt in the insurer's favor would reward careless drafting. Courts interpret rather than void entire contracts, and regulators approve forms rather than settle individual coverage disputes.

**1004. D**

A warranty is incorporated into the contract and held to a strict standard, whereas a representation is a statement believed to be true that is judged by whether it is substantially accurate and material when made. The option that reverses those definitions, making a representation absolutely true and a warranty only substantially true, states the rule backwards. Not every inaccuracy voids a policy, and the distinction turns on the standard of truth applied, not on which party made the statement.

**1005. A**

Waiver is the voluntary surrender of a known right, and estoppel then bars the insurer from reasserting that right after the insured has relied on its conduct. Subrogation concerns recovery from third parties and indemnity concerns restoring the insured financially. Good faith is a mutual duty but does not by itself block the denial the way waiver and estoppel do.

**1006. B**

A physical hazard is a tangible condition of the property that increases the chance or severity of loss, and deteriorated wiring fits precisely. A history of inflated claims and exaggerating a loss are moral hazards rooted in dishonesty. Carelessness because coverage exists is a morale hazard, which reflects attitude rather than a physical condition.

**1007. C**

Avoidance eliminates the exposure by not engaging in the activity at all, which is what discontinuing the product line accomplishes. Retention means absorbing the loss internally, and reduction means taking steps to lessen frequency or severity while continuing the activity. Transfer shifts the financial consequences to another party, typically through insurance or a contract.

**1008. D**

Treaty reinsurance is an ongoing automatic agreement covering an entire category of business, which lets the ceding insurer write eligible risks without case by case approval. Facultative reinsurance is negotiated risk by risk with the reinsurer free to decline. Retrocession is a reinsurer passing risk to another reinsurer, and residual market pools serve applicants who cannot buy coverage voluntarily.

**1009. A**

FAIR Plans are shared market mechanisms created to deliver basic property coverage where private insurers decline to write, often because of location or age of the property. Paying claims of failed insurers is the guaranty association's job. Flood coverage in participating communities comes from the federal flood program, and distributing high risk auto applicants among insurers is the role of an assigned risk plan.

**1010. B**

Beach and windstorm plans are coastal residual markets created specifically to provide wind and hail coverage in designated shoreline areas that private insurers avoid. Assigned risk plans handle hard to place drivers, and guaranty associations respond to insurer insolvency. A rating bureau develops loss costs and classifications rather than issuing coverage.

**1011. C**

An assigned risk plan spreads hard to place drivers across insurers writing auto business in the state, with each carrier taking a share tied to its voluntary market volume. The state administers the plan rather than underwriting and paying claims itself. Surplus lines placement is a separate avenue, and assigned risk premiums are typically higher, not free.

**1012. D**

Surplus lines exists for risks the admitted market will not accept, so producers must show a good faith effort and record declinations before exporting the business. Surplus lines forms and rates are generally exempt from the filing and approval requirements imposed on admitted carriers. FAIR Plans and assigned risk plans are separate mechanisms and are not prerequisites for a surplus lines placement.

**1013. A**

Admitted status means the insurer has been licensed by the state and accepts its filing, solvency, and market conduct oversight, while non-admitted carriers operate through the surplus lines channel without that license. Domicile outside the country describes an alien insurer, a different classification. Neither status is limited to a line of business, and admitted insurers are the more heavily regulated of the two.

**1014. B**

Guaranty associations step in after an admitted insurer fails, funding covered claims through assessments on solvent member insurers, and they are not a source of new coverage. Residual markets solve an availability problem for applicants at the front end. Surplus lines placements are generally not protected by guaranty associations, which is a key disclosure point for consumers.

**1015. C**

The federal flood program imposes a standard thirty day waiting period so that people cannot buy coverage only when a flood is imminent, which would make the program financially unsustainable. Immediate or same day effective dates are not available for ordinary purchases. The limited exceptions relate to loan closings and certain map changes, not to the naming of a storm.

**1016. D**

The program restricts below grade coverage to items such as foundation walls, furnaces, water heaters, and electrical panels, while finished walls, flooring, and most contents in a basement are not covered. Treating a basement like a living area badly overstates the coverage. Saying basements get nothing at all is also wrong, since essential building elements are included.

**1017. A**

Federal flood building and contents coverages are separate purchases with separate limits and deductibles, so a tenant can buy contents alone. The landlord's building coverage protects the structure and never extends to a tenant's belongings. A tenant cannot buy building coverage on property owned by someone else, nor endorse the landlord's policy for personal property.

**1018. B**

Write Your Own companies handle distribution, policy issuance, and claims under their own brand for a fee, but the financial risk of the flood losses stays with the federal program. They are not writing the risk for their own account. Private excess flood products exist separately, and these carriers are administrators rather than reinsurers.

**1019. C**

Flood violates the ideal of independent, widely distributed exposures because one event can devastate an entire region, and only those most at risk would purchase it, which is why a federal program was created. Flood damage is accidental, not intentional. No law bars private flood coverage, and private flood products do exist, and flood losses are severe rather than trivial.

**1020. D**

Increased Cost of Compliance pays toward elevating, relocating, floodproofing, or demolishing a building that a community has declared substantially damaged under its floodplain ordinance. The federal flood program does not provide additional living expense or business income coverage at all. Sandbagging reimbursement is a narrow separate provision and does not fund permanent mitigation.

**1021. A**

The make available requirement obliges insurers to offer terrorism coverage on terms comparable to the rest of the policy, though the insured may reject it. The law does not mandate free coverage or force the insured to buy it. Blanket exclusion is precisely what the statute prevents, and residual market plans have no role in the federal terrorism backstop.

**1022. C**

First party cyber coverage pays the insured's own costs such as forensics, data recovery, notification, and network interruption income, while third party cyber liability defends and pays claims brought by others harmed by the breach. Putting everything under one heading blurs the fundamental first party versus third party distinction. Ransomware is a covered peril under properly written cyber forms.

**1023. B**

Once the app is on, the personal policy's livery exclusion can apply, yet the network company's coverage before a passenger is matched is typically limited, leaving a thin layer of protection that a rideshare endorsement is designed to fill. Network companies generally do provide broader coverage once a ride is accepted. Phone presence is not an exclusion, and commercial auto policies may certainly be written for these drivers.

**1024. D**

Ordinance or law coverage is customarily written in three parts that together address the value of the undamaged portion the insured must destroy, the demolition and removal cost, and the extra expense of rebuilding to current requirements. Dropping any one of the three leaves substantial uninsured cost, because a standard property policy pays only to restore what was actually damaged and its debris removal provision applies to damaged property. This is why code upgrade exposure is a common gap in older buildings.

**1025. A**

Commercial property forms are written for external causes of loss and carve out internal failures such as mechanical or electrical breakdown and boiler rupture, which is exactly the gap equipment breakdown fills, often with resulting damage and business income as well. Fire remains a covered peril under the property form. Property forms do not exclude all damage to machinery or all business income losses; the gap is specifically the internal breakdown perils.

**1026. B**

The law requires a clear and conspicuous disclosure separately stating the terrorism premium and informing the insured that the federal government shares in the payment of certified terrorism losses. Reinsurer identities, company surplus, and class loss ratios are not part of that required notice. The disclosure is generally required both at offer and at policy issuance.

**1027. A**

Standard homeowners policies do not cover flood damage, including rising water and surface water entering the home. Coverage must be purchased separately, most often through the National Flood Insurance Program. The exclusion applies regardless of whether the home is in a mapped flood zone, and there is no percentage sublimit for flood in the standard form.

**1028. C**

Earth movement - including earthquake, landslide, and similar ground movement - is excluded under standard homeowners forms even when triggered by rain or other weather. Coverage is available from many insurers only as a separate policy or endorsement. The suddenness of the event does not defeat the exclusion, and a landslide is not a falling object in the policy sense.

**1029. B**

A standard policy pays to repair or rebuild what was there before the loss; the added expense of complying with building codes and ordinances that did not exist when the home was built is excluded except for any small built-in allowance. An ordinance or law endorsement pays that extra expense. Replacement cost settlement by itself does not add code-upgrade coverage.

**1030. A**

After a covered loss, the insured has a duty to take reasonable steps to protect the property from further damage - for example, boarding up broken windows. Damage that results from neglecting that duty can be denied even though the original windstorm loss is covered. Timely reporting does not cure a failure to protect the property.

**1031. D**

Homeowners insurance is not designed to cover most business uses of the home. Caring for children for pay is a business activity, so the liability claim falls under the business exclusion or a very limited exception; the insured needs separate business coverage. There is no standard sublimit equal to half the liability limit, and injuries to minors are not categorically excluded.

**1032. C**

A homeowners policy is not a maintenance contract; it insures sudden, accidental damage from covered perils, not items that simply wear out or damage that develops gradually from deferred upkeep. Repairing an aging roof is the owner's responsibility, and there is no maintenance surcharge mechanism in the policy.

**1033. B**

Commercial property causes-of-loss forms exclude wear and tear, rust, decay, and gradual deterioration. Insurance is designed for accidental, fortuitous events, and the slow failure of an aging roof is a certainty of ownership rather than a chance event. Roofs are insurable property; it is the cause of loss that defeats this claim.

**1034. A**

Commercial property causes-of-loss forms exclude mechanical breakdown and similar internal failures. Equipment breakdown coverage - historically called boiler and machinery insurance - fills this gap, covering the failure of boilers, machinery, and electrical equipment such as compressors and motors. Business income coverage replaces lost income, not repair costs from an excluded cause.

**1035. D**

Standard commercial property and business income coverage responds to direct physical damage at or affecting the insured premises; failure of utility service caused by damage away from the premises is excluded. A utility services endorsement extends coverage for losses caused by off-premises interruption of power, water, or communications. Waiting periods exist but are much shorter and are not the reason for denial here.

**1036. B**

Property forms exclude loss caused by dishonest or criminal acts of employees. The employee-theft exposure is written under commercial crime insurance or a fidelity bond, which covers an employer's loss from an employee's dishonest acts such as embezzlement. The exclusion, not the reporting timeline, is what defeats the property claim.

**1037. A**

Even open perils forms carry absolute exclusions for war and military action and for nuclear hazard, catastrophic exposures the private insurance market cannot absorb. Fire, burglary damage, and vehicle impact are all covered causes of loss under a special form.

**1038. C**

The CGL's first exclusion removes coverage for injury or damage the insured expected or intended; liability insurance responds to accidents, not deliberate harm. An occurrence is defined as an accident resulting in injury neither expected nor intended. CGL Coverage A expressly covers bodily injury, so option D is wrong for a different reason.

**1039. B**

The CGL liquor liability exclusion applies to insureds in the business of manufacturing, selling, distributing, or serving alcohol, so a tavern must buy a separate liquor liability policy for this exposure. A business NOT in the alcohol business - say, an office hosting a holiday party - retains so-called host liquor protection because the exclusion does not reach it. Location of the injury is irrelevant.

**1040. D**

CGL medical payments cover injuries to persons other than employees that occur on the insured's premises, without regard to fault. Injuries to the insured's own employees arising out of employment are excluded from the CGL because workers compensation is the intended source of recovery. Nothing about glass injuries is separately excluded.

**1041. A**

The CGL excludes bodily injury arising out of the ownership, maintenance, use, or entrustment of any auto (and aircraft or watercraft) operated by an insured. Business vehicle exposure is insured under a commercial auto policy. Employers can be vicariously liable for employees driving on business, so option B is wrong.

**1042. B**

The CGL is not intended to cover claims arising from providing professional services, advice, or design work, so errors like faulty calculations fall to a professional liability (E&O) policy. An umbrella sitting over the CGL generally follows the same professional-services gap, and builders risk is first-party property coverage during construction.

**1043. C**

The CGL's business risk exclusions remove coverage for damage to the insured's own work after completion - the policy is not a warranty of workmanship. Resulting damage to other property, like the homeowner's grill, remains covered under the products-completed operations hazard. Completed operations claims as such are covered, so option B is wrong.

**1044. B**

Actual cash value is generally computed as replacement cost minus depreciation. Here, $18,000 replacement cost minus one-third depreciation ($6,000) leaves $12,000. Choosing $6,000 confuses the depreciation amount with the payment, and

$18,000 would be a replacement cost settlement.

**1045. D**

Under a typical replacement cost provision, the insurer first pays actual cash value and pays the difference - the recoverable depreciation - only after the insured actually repairs or replaces the property and submits receipts. This condition prevents an insured from profiting by collecting full replacement cost without rebuilding.

**1046. D**

Replacement cost and market value are not the same: market value depends on the real estate market and includes the price of the land, while insurance should equal the cost to rebuild the home itself. Insuring to market value can badly over- or under-insure the structure. Deductibles are chosen separately from the limit.

**1047. C**

The coinsurance formula is (amount carried / amount required) x loss. The requirement is 80% of $500,000, or $400,000 - exactly what the insured carried - so the ratio is 1 and the $60,000 loss is paid in full up to the limit. A penalty applies only when the insured carries less than the required amount.

**1048. B**

Homeowners replacement cost provisions generally require the dwelling to be insured to at least 80% of its full replacement cost; when coverage falls below that threshold, the insurer may reduce what it pays on a claim. Underinsurance affects partial-loss settlements rather than voiding the policy, which is why reviewing the limit periodically matters.

**1049. A**

Each loss is capped by the $1 million per-occurrence limit, and all losses together are capped by the $2 million aggregate for the policy period. The first two claims ($900,000 + $800,000 = $1.7 million) leave only $300,000 of aggregate, so the third claim is paid $300,000 even though it is below the occurrence limit. There is no fixed number of covered occurrences.

**1050. C**

Split limits of 100/300/50 mean $100,000 bodily injury per person, $300,000 bodily injury per accident, and $50,000 property damage. Each victim's recovery is first capped at the per-person limit: $100,000 + $80,000 = $180,000, which is within the $300,000 per-accident cap. A single combined single limit policy of $300,000 would instead have paid both claims in full - a key difference between the two structures.

**1051. B**

In standard primary liability policies such as the CGL, defense costs are supplementary payments paid in addition to the limits of liability - they do not erode the amount available for damages. So the insurer pays the $500,000 judgment plus the $60,000 defense, $560,000 total. Policies that reduce limits by defense costs exist but are the exception, not the standard form.

**1052. D**

Umbrella liability insurance provides two kinds of protection: payments in excess of underlying policy limits, and coverage for some exposures - such as libel or slander - that the underlying policies do not cover. When the umbrella responds to a claim no underlying policy covers, the insured typically bears an initial retained amount before the umbrella pays.

**1053. D**

The aggregate limit is the most the policy will pay for all covered losses during a single policy period. Once it is exhausted, no further claims are payable in that period; the aggregate is restored when a new policy period starts, such as at renewal. The occurrence limit cannot resurrect coverage once the aggregate is spent, and reinstatement mid-term is not automatic or free.

**1054. B**

Standard CGL policies exclude liability for injury or property damage caused by the release of pollutants, and pollution cleanup claims are precisely what the exclusion targets. Where the leak started does not restore coverage, and the exclusion applies to civil damage claims, not just regulatory fines.

**1055. A**

Because the CGL excludes pollution claims, a business needing environmental liability protection must buy a special pollution liability policy - often called environmental impairment liability coverage - which covers cleanup costs and third-party bodily injury and property damage from pollution incidents. Raising CGL limits cannot buy back an excluded exposure, and guaranty funds only back up insolvent insurers.

**1056. C**

Federal rules require owners and operators of regulated underground storage tanks to demonstrate financial responsibility: resources to pay for corrective action if a release occurs and to compensate third parties for resulting injury or property damage. Insurance from an insurer or risk retention group is one of the most commonly used mechanisms, alongside state

assurance funds. See epa.gov.

**1057. B**

NFIP building coverage on a residential structure is capped at $250,000; contents coverage is a separate limit capped at $100,000. The full rebuilding cost and the $500,000 figure are wrong because $500,000 is the non-residential building maximum, not the residential one. See fema.gov.

**1058. D**

Non-residential (commercial) buildings can be insured through the NFIP for up to $500,000, with a separate contents limit also available up to $500,000. The $250,000 figure is the residential building maximum, a common trap. See fema.gov.

**1059. A**

The NFIP's standard 30-day waiting period does not apply when the coverage is mandated in connection with a government-backed loan, or when the purchase relates to a community flood map change. Answer B states the general rule but misses the loan-closing exception, which is exactly what this scenario triggers. See fema.gov.

**1060. C**

The standard NFIP policy pays for direct physical flood damage to the building and contents but does not cover additional living expenses or temporary housing while the home is uninhabitable. This is a key gap compared with a homeowners policy, which does include loss-of-use coverage for covered perils. See fema.gov.

**1061. B**

The NFIP defines a flood as a general and temporary condition of partial or complete inundation of two or more acres of normally dry land, or of two or more properties, at least one of which is the policyholder's. Because two properties were inundated by an unusual and rapid accumulation of surface water, the event fits the definition; no disaster declaration or river overflow is required. See fema.gov.

**1062. D**

Private insurers sell excess flood coverage that sits above the NFIP maximums for owners whose exposure exceeds the federal limits. FEMA cannot issue limits above the statutory caps, standard homeowners policies exclude flood, and disaster assistance is neither guaranteed nor a substitute for insurance. See fema.gov.

**1063. A**

Employee theft (fidelity) coverage pays for loss of money, securities, or other property caused by the dishonest acts of an employee, which is exactly what an embezzling bookkeeper is. Robbery coverage requires a threat against a person, and the forgery agreement targets instruments created by outsiders rather than a dishonest employee. See the NAIC glossary definition of fidelity coverage.

**1064. B**

Burglary is the unlawful taking of property from inside premises evidenced by visible signs of forcible entry or exit - the pried door and splintered frame satisfy that requirement. Robbery requires violence or the threat of violence against a person, and no person was present. Legal references define burglary as illegally entering a building intending to commit a crime inside.

**1065. C**

Robbery is the unlawful taking of property from a person, or in a person's presence, by violence or the threat of violence - the weapon pointed at the cashier supplies that element. Burglary instead requires visible signs of forced entry into premises with no confrontation of a person. See the legal definition of robbery at law.cornell.edu.

**1066. D**

Money and securities coverage is split by location: the inside-the-premises agreement applies at the insured's premises or a bank, while the outside-the-premises agreement covers theft, disappearance, or destruction of money and securities in the custody of a messenger away from the premises. The manager acting as messenger on the street is squarely an outside-the-premises loss, and no employee dishonesty or forged instrument is involved.

**1067. A**

The discovery form's trigger is when the loss is discovered, not when it was sustained, so losses from prior years can be covered if first discovered during the policy period (subject to any retroactive date). The loss-sustained form works the other way: the loss generally must occur during the policy period or a prior policy with continuity. Answer B describes the loss-sustained trigger, not the discovery trigger.

**1068. B**

Homeowners forms impose low special dollar limits on theft of jewelry, so a valuable ring is badly underinsured for theft under the unendorsed policy. Scheduling it on a personal articles floater insures it for an agreed or appraised value on an open-perils basis, typically including accidental loss such as a stone falling from its setting. Jewelry is not excluded entirely, so answer A overstates the gap. See iii.org.

**1069. C**

A dry cleaner holding customers' garments is a bailee, and bailee's customers coverage is the inland marine form designed to pay for damage to property of others while in the bailee's care, custody, or control. Standard property coverage on the shop's own contents is not designed to respond to customers' goods this way, and forcing customers onto their own policies would destroy the business's goodwill. The NAIC glossary lists property held by a bailee as a classic inland marine exposure.

**1070. D**

Commercial property forms are designed for property at or near described premises, while inland marine floaters were built for movable property that is regularly at different locations, such as off-road construction equipment. A contractors equipment floater follows the bulldozer from site to site. The other options misstate the coverages: the property policy is not fire-only and floaters do not have to exclude theft. See the NAIC glossary description of inland marine coverage.

**1071. A**

Property in transit over land is a core inland marine exposure, and transit coverage (such as an annual transit policy) insures the owner's goods while they move to their destination. Business income responds to lost earnings from damage at described premises, not to the cargo itself, and the other forms address entirely different property. The NAIC glossary lists property in transit as a defining inland marine class.

**1072. B**

The Nationwide Marine Definition includes instrumentalities of transportation and communication - bridges, tunnels, piers, pipelines, power and telephone lines, and radio and television towers with their equipment - as eligible marine business even though these structures are fixed in place. Their connection to transportation and communication, not mobility, is what qualifies them. Answer A fails because these risks are expressly not movable.

**1073. C**

Twisting is inducing a policyholder to lapse, surrender, or replace existing coverage through misrepresentation or an incomplete comparison. The false insolvency claim used to trigger the replacement is the hallmark. The producer's statement also disparages the insurer, but the defining violation in a replacement induced by misrepresentation is twisting; rebating involves returning part of the commission, which did not occur. See the NAIC Unfair Trade Practices Act model.

**1074. D**

Churning is using the values of an existing policy to purchase replacement coverage with the same insurer primarily to generate new commissions rather than to benefit the client. Twisting is the closely related abuse involving replacement with a different insurer through misrepresentation. No premium was stolen and nothing of value was returned to the client, so misappropriation and rebating do not fit.

**1075. A**

Rebating is returning part of the premium or commission, or giving anything else of significant value, as an inducement to purchase insurance. It is treated as an unfair trade practice under the NAIC model framework because it discriminates among buyers and distorts the sale. Twisting involves misrepresentation to induce replacement, which is not what happened here.

**1076. B**

Producers hold collected premiums and return premiums in a fiduciary capacity, as trustees rather than owners of the funds. Using premium money for personal or business expenses, or mixing it with personal funds, is a breach of that duty regardless of any intent to repay later. Rebating concerns giving value back to the buyer as a sales inducement, which is a different violation. See the NAIC summary of producers' fiduciary responsibilities for premiums.

**1077. C**

Errors and omissions insurance is professional liability coverage that responds when a client suffers loss because of the producer's negligent act, error, or omission - such as failing to procure requested coverage. A CGL policy addresses bodily injury and property damage liability, not purely financial harm from professional mistakes, and a fidelity bond covers employee dishonesty, not negligence. See the NAIC glossary entry for errors and omissions liability.

**1078. D**

An ideally insurable risk requires that losses not be catastrophic - exposure units should be independent so one event cannot damage a large share of them simultaneously. Flood violates this because losses are geographically concentrated, with the added problem that mainly high-risk owners want the coverage. Flood losses are accidental and definite, so those elements are not the obstacle.

**1079. A**

The law of large numbers holds that the larger the number of independent, similar exposure units, the more closely actual loss experience will track expected loss experience, which is what makes credible pricing possible. Indemnity concerns restoring the insured without profit, and subrogation concerns recovery from responsible third parties - neither explains

predictive accuracy.

**1080. B**

Avoidance eliminates a loss exposure entirely by not engaging in the activity that creates it, which is what shutting down the attraction accomplishes. Reduction would be keeping the attraction while adding padding, supervision, or other safeguards; transfer would be shifting the risk through insurance or contract; and retention means knowingly bearing the risk, as with a deductible or self-insurance.

**1081. C**

A hard market is the upswing of the underwriting cycle: premiums increase, coverage terms are restricted, and capacity shrinks as insurers become selective. A soft market is the opposite condition, when losses are low, capacity is plentiful, and pricing is highly competitive. The residual market is a mechanism for risks that cannot find voluntary coverage, not a phase of the cycle.

**1082. D**

Reinsurance is insurance for insurers: the primary company cedes part of the risk it has assumed to a reinsurer, which reduces the ceding insurer's liability, protects it against catastrophe losses, and frees capacity to write additional business. The primary insurer remains fully obligated to its own policyholders, so answer A is wrong - reinsurance is a contract between insurers, not with the insureds. See iii.org, Background on Reinsurance.

**1083. A**

In the three-party surety relationship, the principal (the contractor) owes performance, the obligee (the city) requires the guarantee, and the surety answers if the principal defaults. The bond exists for the obligee's protection, not the principal's - the contractor gains no excuse from performing and remains liable for the default. See law.cornell.edu on surety bonds.

**1084. B**

Suretyship theoretically anticipates no losses: the surety lends its financial strength, and if it must pay the obligee, it has the right of indemnity to recover the full amount from the principal. Insurance works the opposite way - premiums are pooled to fund expected losses that the insurer keeps. That right of recovery against its own bonded party is the key structural difference between a bond and an insurance policy.

**1085. C**

A bid bond guarantees that a bidder, if awarded the contract, will enter into it at the bid price and furnish the required performance security; when the bidder backs out, the bond compensates the obligee, typically for the difference up to the bond penalty. A performance bond responds to default during the work itself, and a payment bond protects subcontractors and suppliers - both apply only after the contract is signed.

**1086. C**

A fidelity bond protects an employer against loss from an employee's dishonest acts, such as theft of cash or securities, so it fits the cashier exposure. A surety bond is a three-party guarantee that a principal will fulfill an obligation owed to an obligee, which fits the licensing requirement. Errors and omissions covers negligent professional mistakes, not dishonesty or guaranteed performance. See the NAIC glossary definition of fidelity coverage.