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## Guidewire ClaimCenter-Business-Analysts New Braindumps Free | Exam ClaimCenter-Business-Analysts Questions Fee

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## Guidewire ClaimCenter Business Analyst - Mammoth Proctored Exam Sample Questions (Q37-Q42):

### NEW QUESTION # 37

Succeed Insurance needs the ability to associate a primary hospital with an injury incident if the injured party received treatment. When treatment is needed, the primary hospital name should display on the injury incident screen along with other details about the injury and treatment received.

The primary hospital should be added to the injury incident in one of the following ways:

- . Select the name from a list of medical care organizations already associated with the claim.
- . Enter the contact details directly in the incident.

. Search the Address Book from the incident to locate a hospital.

Which two requirements must be documented to associate the primary hospital with the claim? (Choose two.)

- **A. A new field on the incident screen to add a contact with a role**
- B. A new Hospital contact subtype
- **C. A new primary hospital role**
- D. A new field in the Address Book to identify a vendor as a hospital

**Answer: A,C**

Explanation:

To implement the functionality of associating a specific contact (the "Primary Hospital") with an entity (the "Injury Incident") in Guidewire ClaimCenter, two core configuration components are required:

\* A new primary hospital role (Option B): In ClaimCenter, the relationship between a Contact and a Claim (or Incident) is defined by a Role. While the contact itself might be a "Medical Care Organization" (existing subtype), the context of its relationship to this specific incident is that it is the

"Primary Hospital". Defining this role allows the system to distinguish this hospital from other medical providers on the same claim.

\* A new field on the incident screen (Option C): To allow the user to select, add, or view this contact, a UI element (specifically a Claim Contact Picker or Input widget) must be added to the Injury Incident screen. This field will be configured to store the relationship and allows the user to perform the required actions: selecting from existing contacts (filtered by the role), entering new ones, or searching the Address Book.

Why other options are incorrect:

\* A (New Subtype): The base product already includes the MedicalCareOrg contact subtype, which is sufficient to store hospital data. Creating a new subtype is unnecessary unless the data structure (fields) of a hospital is fundamentally different from other medical providers.

\* D (Address Book Field): Contacts in the Address Book are typically identified by tags or their Subtype, not by adding a custom field just to identify them as a vendor/hospital.

### NEW QUESTION # 38

A Business Analyst (BA) noticed that one of the User Story Card files for the project indicated that it had recently been modified. The BA wanted to see who changed it, what was changed, and why it was changed.

Where on the Story Card can the BA go to determine the changes recently made to it?

- A. Go to the UI Fields tab > New or Modified fields
- B. Go to File > Properties
- **C. Go to the Document Control tab > Amendment History**
- D. Go to the Action Items tab > Description > Resolution/Comments

**Answer: C**

Explanation:

In the standard Guidewire User Story Card template (an Excel-based tool used for requirements gathering), version control is manually tracked to ensure auditability and clarity among the project team.

\* Document Control Tab (Option C): This is typically the first tab in the Story Card workbook. It contains a section specifically for Amendment History (or Revision History).

\* Content: This section is designed to capture:

\* Who: The author of the change.

\* When: The date of the change.

\* What/Why: A description of the modification (e.g., "Updated Acceptance Criteria based on Workshop feedback").

This provides the specific "Who, What, and Why" requested in the scenario.

Why other options are incorrect:

\* File > Properties (A): This is standard Excel metadata. It shows the "Last Modified By" user and date, but it cannot explain what specific cells were changed or why (the business context).

\* Action Items (B): This tab tracks open questions or tasks, not the revision history of the document requirements.

\* UI Fields (D): This tab tracks the requirements for screen fields, but does not serve as a changelog for the entire document.

### NEW QUESTION # 39

A claim for an auto accident in California has been assigned to an insurance Adjuster in the Midwest region for investigation and processing. The claim has been flagged as "Low Complexity" in ClaimCenter. The Adjuster has an authority limit for total reserves of

\$30,000 and has created reserves totaling \$35,000.

What is the correct approval routing for this transaction?

- A. This transaction will require approval because the Adjuster does not work in the same region where the claim was reported.
- B. The transaction will require approval from another team member who has the authority limit to approve.
- C. This transaction will not require approval because the claim is identified as low complexity.
- **D. The transaction will require approval from the Supervisor of the group.**

**Answer: D**

Explanation:

Based on the Guidewire ClaimCenter Financials and Authority Limits documentation, the correct behavior for this scenario is determined by the strict enforcement of Authority Limits, regardless of claim complexity or geographic region.

In ClaimCenter, every user is assigned specific authority limits for various financial transactions, including reserves, payments, and recovery reserves. These limits are absolute constraints designed to control financial exposure. In the scenario provided, the Adjuster attempted to set a reserve of \$35,000, which exceeds their authorized limit of \$30,000.

When a user submits a financial transaction that exceeds their pre-configured authority limit, ClaimCenter automatically triggers an Approval Workflow. The system validates the transaction amount against the user's limit at the time of submission. Since the limit is breached, the transaction is not committed immediately to the database as "Submitted"; instead, it enters a "Pending Approval" status.

Routing Logic:

The standard, out-of-the-box approval routing logic in ClaimCenter follows the Group Hierarchy.

\* The system identifies the group to which the Adjuster belongs.

\* It creates an Approval Activity.

\* This activity is assigned to the Supervisor of that group.

The Supervisor must then review the transaction. If the Supervisor has sufficient authority (greater than \$35,000), they can approve it. If the Supervisor also lacks sufficient authority, they must still "approve" it to escalate the request further up the hierarchy to their manager, until it reaches a user with sufficient limits.

Why other options are incorrect:

\* A (Complexity): Claim complexity flags (e.g., "Low Complexity") are often used for Assignment rules (Segment-based assignment) or straight-through processing of documents, but they do not override Financial Authority controls. A low-complexity claim still requires financial oversight if the dollar amount is high.

\* B (Peer Approval): Approval routing is hierarchical, not peer-to-peer. It does not look for "any" team member; it looks specifically for the defined Supervisor.

\* C (Region): The region mismatch might trigger an assignment rule or a validation warning depending on configuration, but the specific trigger for the approval here is purely the financial discrepancy (\$35k > \$30k), not the geography.

#### **NEW QUESTION # 40**

Succeed Insurance allows field Adjusters to write checks directly to the insured to cover damage costs for minor claims such as:

\* Personal auto claims involving cracked windshields

\* Homeowners claims involving minor glass breakage

The Adjuster uses the Manual Check Wizard to record the check number and amount against a reserve line.

Succeed requires Supervisor approval for all manual checks to ensure that the paper checks are verified against the payment information in ClaimCenter.

Which two limits or rules must be configured in ClaimCenter to ensure that these manual payments are sent to the correct person for approval? (Choose two.)

- A. Approval routing rules
- **B. Authority limits**
- **C. Transaction approval rules**
- D. TransactionSet validation rules

**Answer: B,C**

Explanation:

To enforce an approval workflow for a specific type of financial transaction (like "Manual Checks") regardless of the dollar amount, a Business Analyst must leverage both Authority Limits and Transaction Approval Rules.

\* Authority Limits (D): These are the primary controls for financial exposure. While typically used for amounts (e.g., "Limit of

\$5,000"), they are the foundational mechanism that triggers the system's

"Pending Approval" state. For this scenario, an authority limit could be set to \$0 for the specific payment method of "Manual Check" to force all such payments into the approval workflow.

\* Transaction Approval Rules (C): These rules allow for more granular, logic-based approval triggers beyond simple amounts. Since the requirement specifies "all manual checks" (implying a condition based on the method of payment, not just the amount), a Transaction Approval Rule is the best practice configuration. The rule would be written to state: "If Payment Method is Manual, then Approval is Required."

\* Why not A (Approval Routing)? While Approval Routing rules determine who receives the request (the "correct person"), the default behavior in ClaimCenter is to route approvals to the user's Supervisor.

Since the requirement is simply "Succeed requires Supervisor approval," the standard routing logic likely suffices without needing new custom configuration. The critical configuration needed is the trigger (C and D) to stop the payment in the first place.

#### NEW QUESTION # 41

Losses incurred because of an accident with other vehicles can be very large. Because of the risk of large losses, all claims must include both a police report and the details of any passengers in the vehicle, whether they sustained injuries or not. The claim must show whether there were passengers in the vehicle at the time of the accident. Succeed wants the ability to include a very detailed description of the loss event information on intake of the claim.

When the claim is created, Succeed wants to flag the claim with a reminder for the Adjuster to contact the insured.

There should be reminders for the Adjuster to complete the following items for every new claim created:

- . Review any photographs of the accident
- . Contact and Interview each passenger
- . Collect statements from each witness
- . Record the vehicle's mileage

Which business requirement is based on assumptions?

- A. There should be reminders for the Adjuster to complete the following items for every new claim created: collect statements from each witness.
- **B. There should be reminders for the Adjuster to complete the following items for every new claim created: review any photographs of the accident.**
- C. When the claim is created, we want to flag the claim with a reminder for the Adjuster to contact the insured.
- D. All claims must include both a police report and the details of any passengers in the vehicle, whether they sustained injuries or not.

**Answer: B**

Explanation:

In the context of business requirements analysis, an assumption is a statement that is accepted as true or certain to happen without proof.

\* Why A is the correct answer: The requirement to generate a reminder to "review any photographs" for every new claim assumes that photographs will be available for every accident. In reality, photos are not always taken or provided at the First Notice of Loss (FNOL). Creating a mandatory task for an optional piece of evidence is based on the assumption of data availability.

\* Why D is incorrect: "All claims must include a police report..." is a Business Rule or constraint. It is a mandatory condition imposed by the business ("must include") rather than an assumption about what is currently present.

\* Why B is incorrect: Contacting the insured is a standard, universal step in the claims process that applies to every claim, so it is not considered an assumption.

#### NEW QUESTION # 42

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