New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 training pdf vce & NY-Life-Accident-and-Health online test engine & New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 valid practice demo

NY Life, Accident, and Health Insurance Agent/Broker Exam Series 17-55

Process 2103 (d-i) - ANS 1. The Superintendent may issue a license to any person, firm or corporation who has complied with the requirements of the Insurance Code, authorizing the licensee to act as agent of any authorized insurer. Every individual applicant for a license under this section and every proposed sub-licensee must be 18 years of age or older at the time of issuance of such license. The person must submit to and pass a written examination required by the Superintendent.

Producer Definition (2101(k)) - ANS An insurance producer means an insurance agent, insurance broker, reinsurance intermediary, excess lines broker, or any other person required to be licensed under the insurance laws of this state to sell, solicit or negotiate insurance.

Who Should be Licensed (2101(k)(1)) - ANS 1. The term "insurance producer" does not include: An officer, director or employee of a licensed insurer, fraternal benefit society or health maintenance organization or of a licensed insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:
(a) the officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance;
(b) the officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or (c) the officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting licensed insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance.

Home State (2101(l)) - ANS Home state means the District of Columbia or any state or territory of the United States in which an insurance producer maintains his, her or its principal place of residence or principal place of business and is licensed to act as an insurance producer.

Negotiate (2101(m)) - ANS Negotiate or negotiation means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from licensed insurers, fraternal benefit societies or health maintenance organizations for purchasers.

Sell (2101(n)) - ANS Sell or sale means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of a licensed insurer, fraternal benefit society or health maintenance organization.

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Our experts update the NY-Life-Accident-and-Health training materials every day and provide the latest update timely to you. If you have the doubts or the questions about our product and the purchase procedures you can contact our online customer service personnel at any time. We provide the discounts to the old client and you can have a free download and tryout of our NY-Life-Accident-and-Health Test Question before your purchase. So there are many merits of our product. You can know the characteristics and the functions of our NY-Life-Accident-and-Health practice test by free demo before you purchase our NY-Life-Accident-and-Health exam questions.

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Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q21-Q26):

NEW QUESTION # 21
Which of the following statements is TRUE concerning classification of risks?

- A. Preferred risks pay a lower premium than standard risks.
- B. A preferred individual is issued a rated policy.
- C. Substandard applicants are never issued policies.
- D. Rated policies merit lower premiums.

Answer: A

Explanation:
The true statement is D. Preferred risks pay a lower premium than standard risks. In life insurance underwriting, applicants are commonly grouped into classifications such as preferred, standard, and substandard (or rated) . A preferred risk is an insured who presents a lower-than-average likelihood of loss compared with a standard applicant, so that class generally receives more favorable premium rates. The NAIC glossary defines a preferred risk as an applicant whose likelihood of loss is lower than that of the standard applicant, which directly supports the lower-premium result.
The other choices are false. Substandard applicants are not "never" issued policies ; many are issued coverage, but usually at a higher premium through a rating . A rated policy means the insurer has charged extra because of higher risk, so it does not merit a lower premium. Likewise, a preferred individual is not issued a rated policy; preferred status reflects better-than-standard risk, while rated or substandard status reflects higher-than-standard risk. New York DFS's Life, Accident and Health exam outline includes classification of risks as a tested underwriting topic, consistent with this principle.

NEW QUESTION # 22
According to Health Insurance Portability and Accountability Act (HIPAA), when can a group health policy renewal be denied?

- A. Participation or contribution rules have been changed.
- B. The size of the group has increased by more than 10%.
- C. There have been too many claims in the previous year.
- D. Participation or contribution rules have been violated.

Answer: D

Explanation:
The correct answer is Participation or contribution rules have been violated . Under the Health Insurance Portability and Accountability Act (HIPAA), group health insurance plans are generally subject to guaranteed renewability requirements . This means that insurers must typically renew group coverage at the option of the employer or plan sponsor. However, HIPAA provides a few limited exceptions where renewal may legally be denied.
One of these exceptions occurs when the employer or group policyholder fails to comply with the insurer's participation or employer contribution requirements . Participation rules usually require a minimum percentage of eligible employees to enroll in the plan, while contribution rules require the employer to pay a specified portion of the premium. If the employer fails to meet these requirements or violates the contractual conditions, the insurer may have grounds to deny renewal of the group policy .
The other choices are incorrect. HIPAA does not allow insurers to deny renewal simply because the group had high claims experience , because the group size increased , or because contribution rules were changed . The critical factor is violation of participation or contribution requirements , making Option C the correct answer.

NEW QUESTION # 23
If a policyowner surrenders a policy for its cash value, when is a tax liability incurred?

- A. The cash value exceeds all premiums paid.
- B. The policy is exchanged for a policy of equal value.
- C. The policy is transferred to a third party.
- D. The cash value is less than premiums paid.

Answer: A

Explanation:
A tax liability is incurred upon surrender of a life insurance policy when the cash surrender value received exceeds the total premiums paid into the policy , excluding any amounts previously withdrawn tax-free. In life insurance taxation, the policyowner's cost basis is generally the sum of premiums paid. If the amount received at surrender is greater than that basis, the excess is treated as taxable ordinary income . For that reason, A is correct.
Choice B is incorrect because if the cash value is less than the premiums paid, there is generally no taxable gain. Choice C is incorrect because an exchange of one life insurance policy for another policy of equal value may qualify as a 1035 exchange , which allows the transaction to occur without immediate taxation, provided it meets the tax code requirements. Choice D is not the best answer to this question because the issue asked is specifically about surrender for cash value, and the taxable event in that context depends on whether the policyowner receives more than the policy's basis. On licensing exams, "cash value exceeds premiums paid" is the key rule.

NEW QUESTION # 24
Which of the following is NOT an Essential Health Benefit Category under the Affordable Care Act?

- A. Emergency Services.
- B. Alternative Medicine.
- C. Maternity and Newborn Care.
- D. Laboratory Services.

Answer: B

Explanation:
The Affordable Care Act (ACA) requires non-grandfathered individual and small group health plans to cover Essential Health Benefits (EHBs) -a defined set of benefit categories that must be included to ensure comprehensive coverage. The EHB categories include, among others, emergency services , laboratory services , and maternity and newborn care , all of which are explicitly listed as required categories. These categories ensure access to critical care such as emergency treatment, diagnostic testing and screenings through lab services, and prenatal, delivery, and newborn-related services.
" Alternative Medicine " is not one of the ACA's EHB categories. While some plans may choose to cover certain alternative or complementary treatments (for example, limited chiropractic or acupuncture benefits), such services-when covered-are typically plan-specific design choices or may be addressed under broader categories only if the state's EHB benchmark defines them that way. The ACA does not mandate "Alternative Medicine" as a standalone essential benefit category in the way it mandates emergency, lab, and maternity
/newborn coverage. Therefore, the option that is NOT an Essential Health Benefit Category is Alternative Medicine .

NEW QUESTION # 25
Medicaid provides which coverage that Medicare does NOT?

- A. inpatient hospital services
- B. ambulance services
- C. custodial care
- D. inpatient psychiatric care

Answer: C

Explanation:
The correct answer is custodial care . Medicaid is a government health assistance program for individuals who meet certain income and resource requirements , and one of its important features is that it may provide coverage for long-term custodial care ,

particularly in a nursing home or similar setting for eligible individuals. Custodial care generally refers to assistance with activities of daily living , such as bathing, dressing, eating, and moving about, rather than treatment intended to cure or improve a medical condition.
Medicare, by contrast, is primarily designed to cover acute care and medically necessary services. It does cover services such as ambulance transportation , inpatient hospital services , and certain forms of inpatient psychiatric care , subject to policy limits and eligibility requirements. However, Medicare generally does not pay for ongoing custodial care when that is the only type of care needed.
This distinction is commonly tested in accident and health insurance licensing exams because it highlights the difference between medical insurance for acute or skilled care and public assistance coverage for long-term support needs . Therefore, the service Medicaid provides that Medicare does not is custodial care .

NEW QUESTION # 26
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