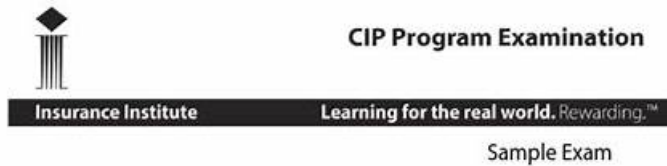


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C11 Principles and Practice of Insurance

IMPORTANT

The time allowed for this exam is 3 hours.

Total marks: 200

You must hand in this paper and any paper used for rough work to the supervisor when you leave the examination room. Failure to do so may result in disqualification.

Section A: Multiple-Choice Questions

Question 1. For the following multiple-choice questions, fill in the circle of the letter that identifies the most correct answer.

Example: A B C D

**DO NOT MARK THE ANSWERS ON THESE PAGES.
USE THE FIRST PAGE OF YOUR ANSWER BOOK.**

1. Insurance was developed as a result of the existence of
- (A) hazards.
 - (B) indemnity.
 - (C) loss.
 - (D) risk.

Page 1 of 9

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IIC Principles and Practice of Insurance Sample Questions (Q28-Q33):

NEW QUESTION # 28

Why does the need for liability insurance arise?

- A. Uphold ethical feelings of responsibility
- B. Meet societal obligations and norms
- C. Reduce personal risk to oneself
- **D. Fulfill legal obligations to others**

Answer: D

Explanation:

Liability insurance arises because individuals and businesses have legal obligations not to cause bodily injury or property damage to others. When someone is negligent, the law allows the injured party to seek compensation. These legal obligations can be substantial and financially devastating. Liability insurance provides protection by transferring the financial burden of compensating others to an insurer. It ensures that the insured can meet their legal responsibilities and that injured third parties receive compensation.

Option A is incorrect because liability insurance is not for protecting oneself from personal risk-it protects against obligations to others. Option C refers to social norms, which may influence behavior but do not impose enforceable financial duties. Option D refers to ethics, but ethical feelings alone do not create legal liability.

The key reason liability insurance exists is the legal requirement to compensate others when negligent, making B the correct answer.

NEW QUESTION # 29

Which statement best describes unearned premium?

- A. The accumulated premium that has not been paid out against a loss
- **B. The premium that covers the policy duration that has not yet passed**
- C. The earned premium that has been paid out as the broker's commission
- D. The premium that covers the policy period that has expired

Answer: B

Explanation:

Unearned premium is the portion of the premium that corresponds to the period of insurance not yet elapsed.

When an insured prepays a premium (often for a 12-month policy), the insurer earns that premium gradually over the policy term as time passes. Any amount relating to future coverage-coverage the insurer has not yet provided-is considered unearned premium. It represents a liability on the insurer's balance sheet because if the policy is cancelled, the insurer must refund the unearned portion to the insured, subject to policy terms.

Option A is the opposite: that describes earned premium, not unearned premium. Option B is incorrect because unearned premium is unrelated to claims payments; it is a time-based accounting concept. Option D is incorrect because broker commissions are not part of earned or unearned premium calculations; they are an expense paid out of the premium.

Therefore, the correct definition is C: the premium for the remaining period of insurance that has not yet passed.

NEW QUESTION # 30

Rashida claims she told her broker about the swimming pool when binding coverage. The adjuster disputes coverage because the insurer was not informed. What should have been done to prevent this dispute?

- A. Broker should have requested a witness during the oral application
- **B. Broker should have sent written confirmation to Rashida and the insurer**
- C. Broker should have requested Rashida send in a signed notice after issuance
- D. Insurer should have contacted Rashida directly before binding coverage

Answer: B

Explanation:

Whenever coverage is bound orally, the broker must follow up with written confirmation to both: the insured, to confirm the accuracy of information provided, and the insurer, to notify them of all disclosed underwriting details.

This written documentation protects all parties by ensuring the insurer is fully aware of material facts—such as the presence of a swimming pool—and prevents disputes like this one.

Option A is unnecessary and not industry practice.

Option C refers to a notice after issuance, but the dispute occurred at binding, so this is too late.

Option D is incorrect; the insurer does not verify every detail directly with insureds—this is the broker's responsibility.

Thus, the broker should have completed written confirmation, making B the correct answer.

NEW QUESTION # 31

Insurer A and Insurer B cover the same building and the policies are NOT subject to contribution. The building sustains a loss of \$450,000. How can the insured claim for their loss?

Insurer	Insured Amount
Insurer A	\$800,000
Insurer B	\$200,000

- A. Claim the full amount from insurer A
- B. Claim 50% of the loss from each insurer
- C. Claim the full amount from Insurer B and request them to subrogate against Insurer A
- D. Claim the full amount from Insurer A and have Insurer B pay the loss deductible

Answer: A

Explanation:

When two insurers cover the same property but the policies are not subject to contribution, this means the insurance contracts are written so that each insurer is liable as if no other insurance exists. In effect, the insured may claim the full loss amount from either insurer, regardless of the proportional limits written on each policy.

This distinguishes the situation from typical concurrent insurance, where losses are shared proportionally.

Because contribution does not apply here, the insured has full freedom to choose which insurer will pay the claim, up to the policy limit.

In this scenario:

The loss is \$450,000.

Insurer A's limit is \$800,000, enough to pay the full claim.

Insurer B's limit is \$200,000 - insufficient to cover the entire loss.

Since contribution does not apply, the insured can claim the entire \$450,000 from Insurer A without involving Insurer B. Insurer A cannot require the insured to claim part of the loss from Insurer B, nor can the insured demand that B pay part unless they choose to claim from B.

Option B is incorrect because proportional sharing only applies when contribution is explicitly activated.

Option C is incorrect because Insurer B does not owe anything unless the insured submits a claim to them.

Option D is incorrect because subrogation applies after paying a claim—B cannot pay and then pursue A, since A is not legally responsible for B's voluntary payment.

Thus, the only correct choice is A.

NEW QUESTION # 32

What should the broker provide in the broker report?

- A. Their suggested premium for the client
- B. Any personal knowledge of the client
- C. The client's past premium and deductibles
- D. Comparable accounts to assist the insurer in rating

Answer: B

Explanation:

A broker report accompanies an application submitted to an insurer. Its purpose is to give the underwriter helpful background information to properly assess the risk. The broker is expected to provide personal knowledge of the client that may not be evident from the application itself, such as reputation, financial responsibility, prior behaviour, and risk-management practices. This

information can significantly influence underwriting decisions.

Option A is incorrect-the insurer, not the broker, determines premium

Option C may be included if relevant, but it is not the essential purpose of a broker report.

Option D (comparable accounts) is not standard practice; insurers rely on their own rating manuals and actuarial data.

Thus, the most appropriate and expected content in a broker report is personal knowledge of the client, making B the correct answer.

NEW QUESTION # 33

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