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NY Life, Accident, and Health Insurance Agent/Broke

Exam Series 17-55

1. Process 2103 (d-i): 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.

2. Producer Definition (2101(k)): 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.

3. Who Should be Licensed (2101(k)(1)): 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,

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Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q22-Q27):

NEW QUESTION # 22

Which approach considers the future needs of the survivors in determining amounts of life insurance?

- A. Human Life Value Approach.
- **B. Needs Approach.**
- C. Cost Comparison Approach.
- D. Living Benefits Approach.

Answer: B

Explanation:

The Needs Approach is a method used to determine the appropriate amount of life insurance by analyzing the financial needs of the insured's survivors after the insured's death. This approach focuses on calculating how much money dependents will require to maintain financial stability and meet future obligations. Under this method, several categories of needs are considered, including immediate expenses (such as funeral costs, medical bills, and estate settlement costs), ongoing living expenses for surviving family members, debt repayment (such as mortgages, loans, or credit obligations), and future financial goals like children's education or spousal retirement needs. The total of these financial requirements is calculated, and any existing assets or resources available to the family are subtracted to determine the amount of life insurance needed.

In contrast, the Human Life Value Approach focuses on the insured's

NEW QUESTION # 23

Some states have laws ensuring that health insurance coverages are available at a reasonable cost and under reasonable conditions for small employers. Small employers are defined as having no more than

- **A. 100 employees.**
- B. 200 employees.
- C. 150 employees.
- D. 75 employees.

Answer: A

Explanation:

The correct answer is 100 employees. In accident and health insurance licensing material, "small employer" or "small group" generally refers to an employer with 1 to 100 employees for purposes of small-group health insurance market rules. These laws are intended to make coverage more available and affordable for smaller businesses that may not have the bargaining power of large employers. They are commonly associated with protections involving availability of coverage, renewal standards, rating limitations, and fair underwriting conditions in the small-group market.

This question tests recognition of the standard upper limit used in modern health insurance regulation for a small employer group. The other options-75, 150, and 200-do not match the commonly tested definition.

In exam context, the purpose is to distinguish small-group health coverage from large-group coverage, because different rules may apply to eligibility, premium determination, and mandated access. So, when a health insurance question asks how many employees a "small employer" may have under these types of laws, the expected answer is no more than 100 employees.

NEW QUESTION # 24

What information must be included in the statement accompanying an insurance claim payment made by an insurer?

- A. The agent ' s name and address
- B. A list of all claimants involved
- C. The reinsurance carrier involved
- **D. The coverage under which the payment is being made**

Answer: D

Explanation:

When an insurer issues a claim payment, New York claims-handling standards require that the payment be accompanied by an explanation that clearly identifies what the payment represents . A key required item is the coverage under which the payment is being made , so the claimant (or insured) can understand the basis for the payment and how it relates to the policy's benefits. This helps avoid confusion when a policy includes multiple coverages, benefit limits, deductibles, copayments/coinsurance, or when only part of a claim is payable. Stating the applicable coverage (for example, hospital confinement, major medical, disability income, accidental death, etc.) supports transparency and aligns with fair claims settlement practices by showing that the insurer is paying according to the policy provisions.

The other options are not required elements of the payment statement. Insurers are not required to list all claimants, disclose reinsurance arrangements (which are typically not visible to policyholders), or include the agent's name and address as part of the claim payment explanation. The essential requirement tested here is identifying the coverage supporting the payment.

NEW QUESTION # 25

The insured ' s long-term care insurance policy will refund a portion of the premium if they die during the term of the policy. This is because the policy has a

- **A. return of premium benefit.**
- B. waiver of premium benefit.
- C. cash surrender value option.
- D. reduced paid-up option.

Answer: A

Explanation:

The correct answer is return of premium benefit . In long-term care insurance, a return of premium rider or benefit provides that if the insured dies while the policy is in force, some or all of the premiums paid may be refunded, usually to a beneficiary or the insured's estate, depending on the terms of the contract. This feature is designed to reduce the concern that the insured may pay premiums for many years and never use the policy' s long-term care benefits.

This benefit is different from a waiver of premium , which suspends premium payments after the insured qualifies for benefits under the policy, typically after a waiting period. It is also different from a reduced paid- up option , which allows coverage to continue at a reduced benefit level without further premium payments, and from a cash surrender value option , which generally applies when the policy is voluntarily surrendered rather than when the insured dies.

Because the question specifically states that a portion of the premium is refunded upon death during the term of the policy , the policy feature being described is the return of premium benefit . Therefore, Option B is correct.

NEW QUESTION # 26

A common disaster clause states that if the beneficiary dies from the same accident as the insured individual, the insurer will proceed as if the

- A. beneficiary and the insured individual died simultaneously.
- B. beneficiary outlived the insured individual.
- C. beneficiary was never named on the policy.
- **D. insured individual outlived the beneficiary.**

Answer: D

Explanation:

A common disaster clause (often discussed with "simultaneous death" situations) addresses what happens when the insured and the primary beneficiary die in the same accident and it is unclear who died first or they die within a very short period. To prevent the death benefit from being paid to the beneficiary's estate (and potentially creating delays, disputes, or unintended distribution), the policy provision directs the insurer to handle the claim as though the insured survived the beneficiary . When the insurer proceeds on that assumption, the primary beneficiary is treated as having predeceased the insured, so the death benefit is paid to the contingent

beneficiary if one is named. If there is no contingent beneficiary, proceeds generally go according to the policy's default order (often to the insured's estate).

This clause helps ensure the insured's intended "next in line" recipients receive the proceeds and reduces administrative complications when deaths occur together. Therefore, the insurer proceeds as if the insured individual outlived the beneficiary.

NEW QUESTION # 27

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