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Guidewire ClaimCenter-Business-Analysts Exam Syllabus Topics:

Topic	Details
Topic 1	• Quality Analyst Basics: This domain covers quality assurance fundamentals including driving quality throughout development, integrating quality from inception, risk assessment and mitigation, test strategy selection, and defect management processes.
Topic 2	• Claim Center Data Model and Adjudication: This domain examines ClaimCenter's data model architecture, claim setup, adjudication processes, financial terminology and concepts, and payment creation procedures.
Topic 3	• Claim Processes and Maintenance: This section focuses on end-to-end claims processes, organizational structure setup, line of business coverage configuration, claim intake procedures, and ongoing claim maintenance activities.

Topic 4	• Behavior Driven Development at Guidewire: This section introduces BDD methodology and its application in Guidewire implementations, focusing on collaborative development approaches and writing clear, testable requirements using BDD principles.

Guidewire ClaimCenter Business Analyst - Mammoth Proctored Exam Sample Questions (Q33-Q38):

NEW QUESTION # 33
Succeed Insurance handles a small volume of asbestos claims in their legacy system. These claims can remain open for many years to cover medical costs to claimants due to illnesses caused by exposure to asbestos in the workplace.
Succeed has the following requirements for paying these claims with the New Check Wizard:
. No indemnity (claim cost) payments can be made until a medical assessment of the claimant is completed.
. Expense payments can be made to cover Succeed's costs to process the claim.
Which feature in the base product can be extended to support both of these requirements?

- A. Financial holds
- B. Transaction approval rules
- C. Claim Maturity Level - Ability to pay
- D. Authority Limits

Answer: C

Explanation:
250 to 350 words From Exact Extract of Guidewire ClaimCenter Business Analyst documentation:
The requirement to block specific types of payments (Indemnity) while allowing others (Expenses) based on the status of claim data (Medical Assessment) is best handled by Validation Rules at the Ability to Pay level.
* Ability to Pay (Option D):In Guidewire ClaimCenter, the "Ability to Pay" is a specificValidation Level. When a user attempts to issue a check, the system runs a set of validation rules to ensure the claim has reached a sufficient level of maturity and data completeness. This is the "gatekeeper" for payments.
* How it works for this scenario:A Business Analyst can define a validation rule at the "Ability to Pay" level that states:"If the Payment Type is Indemnity AND the Medical Assessment is incomplete, then raise an error."
* Why it fits:This logic perfectly satisfies both requirements.
* It blocks Indemnity payments if the assessment is missing.
* It implicitly allows Expense payments to proceed because the rule only checks for Indemnity payments.
Why other options are incorrect:
* Authority Limits (A)control theamountof money a user can approve, not the prerequisites for payment.
* Transaction Approval Rules (B)are used to route checks for supervisory review based on criteria, not to block them entirely due to missing data.
* Financial Holds (C)are generally applied to a whole claim or exposure to suspendallpayments (or broadly all payments of a certain category). While possible to configure, they are less flexible than Validation Rules for checking specific data fields like "Medical Assessment" dynamically during the check wizard process.

NEW QUESTION # 34
To optimize business process workflow, an insurer has spent a great deal of effort on estimating the amount of effort required to complete various types of work... They are also aware that certain situations may require specialized expertise and want to incorporate this in their decision making.
All claims and exposures are entered using only the ClaimCenter new claim wizard. Once entered, the work should be automatically distributed fairly to those properly suited, as determined by the company's knowledge of each worker's skill set.
Which two assignment mechanisms, alone or together, will achieve their goal? (Choose two.)

- A. Weighted workload
- B. User attribute
- C. FNOL queues
- D. Supervisor assignment
- E. Round-robin

Answer: A,B

Explanation:
To meet the dual requirements of "specialized expertise" and "fair distribution based on effort," the Business Analyst should utilize User Attributes and Weighted Workload assignment rules.
* User Attributes (Option B):This feature handles the "specialized expertise" requirement.
Administrators can tag users with specific attributes (e.g., "Bilingual," "Heavy Equipment Expert," "Litigation Specialist"). Assignment rules can then be configured to filter the pool of potential assignees toonlythose who possess the matching attribute for the specific claim type.
* Weighted Workload (Option D):This feature handles the "fair distribution" and "amount of effort" requirement. Unlike Round-robin (which treats all claims as equal), Weighted Workload assigns a "weight" (effort points) to the claim and tracks the "load factor" (current capacity) of the user. The system assigns the new work to the user with the lowest relative workload, ensuring that adjusters handling difficult, high-effort claims are not overwhelmed with the same volume as those handling simple claims.
Why other options are incorrect:
* Round-robin (A):Distributes work purely cyclically (1-2-3-1-2-3) without regard for the user's current workload or the complexity of the claim.
* FNOL Queues (C):This is a "pull" mechanism where work sits in a bucket until someone grabs it, rather than the "automatic distribution" (push) requested.
* Supervisor Assignment (E):This is manual, not automatic.

NEW QUESTION # 35
An auto accident in Chicago, Illinois has been reported to Succeed Insurance. The customer service representative uses the ClaimCenter standard Claim Wizard to set up the new claim. The policy is verified in effect and based on the reported exposures the total loss points calculated is 38. There is also a note to have an expert inspection via approved vendor.
What is the most likely claim setup with regards to this reported auto accident?

- A. The new claim will be segmented as mid-complexity auto claim, assigned to Midwest Low Complexity Auto Adjusters Group, with activity for vehicle inspection.
- B. The new claim will be segmented as high complexity auto claim, assigned to a Supervisor for further determination on next steps due to complexity.
- C. The new claim will be segmented as low complexity auto claim, assigned to Midwest Low Complexity Auto Adjusters Group, with activity for vehicle inspection.
- D. The new claim will be segmented as high complexity auto claim, assigned to Midwest Complex Auto Adjusters Group, with activity for vehicle inspection.

Answer: D

Explanation:
ClaimCenter uses a logic-based process called Segmentation to categorize claims and Assignment to route them.
* Complexity (Points):The "Total Loss Points" score of38is significantly high. In standard configuration, high scores (typically indicating severe damage or total loss potential) trigger aHigh Complexitysegmentation.
* Assignment (Geography):The accident occurred inChicago (Midwest). The assignment rules will match the geography (Midwest) with the complexity (High/Complex). Therefore, it routes to the Midwest Complex Auto Adjusters Group.
* Workplan (Activity):The specific note regarding an "expert inspection" translates into a generated Activity(likely "Assign Vehicle Inspection" or similar) added to the claim's workplan.
Why other options are incorrect:
* A & D (Low/Mid Complexity):A score of 38 is too high for "Low Complexity" (which is usually for simple fender benders). Assigning a complex claim to a "Low Complexity" group would violate standard routing logic.
* C (Supervisor):Modern ClaimCenter configurations prefer Straight-Through Processing (STP) to a working group. Routing to a Supervisor is generally a fallback for exceptions, whereas this is a standard high-severity scenario that should go directly to the specialized adjusters.

NEW QUESTION # 36
An Adjuster at Succeed Insurance increases the reserve on a claim's exposure from $1,000 to $1,500 to account for inflation in repair costs. A week later, a Supervisor reviews the claim and wants to know specifically who made this change, the exact date and time it was made, and what the previous value was.
The Supervisor needs a chronological audit trail of changes to the claim file without navigating through complex financial ledgers.
Which screen in the ClaimCenter user interface should the Supervisor access to find this information?

- A. Loss Details > Status
- B. History
- C. Financials > Transactions
- D. Notes

Answer: B

Explanation:
In Guidewire ClaimCenter, the History screen serves as the automated audit trail for the claim file. It is designed to capture and display a chronological list of significant events and user actions that have occurred throughout the claim's lifecycle.
* Audit Trail Functionality:The History screen automatically records specific types of events, including:
* Field Changes:When critical fields (like Reserve Amounts) are modified, the system logs the "Old Value" and the "New Value."
* Assignment Changes:Tracks when the claim was transferred from one user to another.
* Rule Execution:Logs when specific business rules (like "Exception Flagged") are triggered.
* Data Points:For each entry, the History screen displays theUserwho performed the action, the Timestampof the event, and aDescriptionof the change.
Why other options are incorrect:
* Financials > Transactions (A):While this screen shows the financial T-account entries (debits/credits) for the reserve increase, its primary purpose is accounting analysis. It is less efficient for a supervisor looking for a simple "Who/When/What" audit trail compared to the History screen.
* Notes (C):Notes are typically used for qualitative narratives and manual entry. While a system notecan be generated for a reserve change, the History screen is the dedicated, non-editable system of record for tracking field changes.
* Loss Details > Status (D):This screen shows thecurrentstate of the claim (e.g., Open, Closed, Litigation Status) but does not provide a historical log of previous values or the specific user actions that led to the current state.

NEW QUESTION # 37
During claim intake and adjudication, Adjusters capture contact information for the insured and all claimants.
To improve customer service and reduce the time required to reach these contacts to gather additional claim information, Succeed Insurance will capture the preferred contact method for all person contacts. The new field will be added to the contact details screen of the user interface (UI) as a drop-down list displaying all valid contact methods including email, mail, and phone.
Which version correctly lists the preferred contact methods in the Typelists tab of the Parties Involved User Story Card?

- A. Option D
- B. Option B
- C. Option A
- D. Option C

Answer: B

Explanation:
To correctly document a Typelist in a User Story Card, the Business Analyst must understand both the data structure (Codes vs. Names) and the configuration state (New vs. Modified).
* Code Validity:In Guidewire, aTypecode(the value stored in the database) must be a unique identifier for each option in the list.
* Option Bcorrectly lists distinct codes: email, mail, and phone.
* Options A and Care incorrect because they list theTypelist Name(PreferredContactMethod) as the Codefor every single row. You cannot have multiple entries with the same primary key (Code) in one list.
* Configuration State (New vs. Modified):The PreferredContactMethod typelist is a standardBase Productfeature in Guidewire ClaimCenter. It already exists out-of-the-box.
* Option Bcorrectly identifies the Status as"Modified". When you add values to or configure an existing base typelist, you document it as "Modified".
* Option Dis incorrect because it lists the Status as"New". This would imply creating a brand new custom typelist (e.g., MyCustomList_Ext), which is not necessary for standard contact methods.
Therefore,Option Bis the only version that has valid, unique codes and the correct configuration status.

NEW QUESTION # 38
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