High Hit Rate ClaimCenter-Business-Analysts Exam Outline Covers the Entire Syllabus of ClaimCenter-Business-Analysts

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Guidewire ClaimCenter-Business-Analysts Exam Syllabus Topics:

Topic	Details
Topic 1	• 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.
Topic 2	• InsuranceSuite Analyst Fundamentals: This domain covers InsuranceSuite platform fundamentals including user interface, data model, application logic, integration mechanisms, and hands-on workshop exercises for practical application.

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.

ClaimCenter-Business-Analysts Question Explanations & ClaimCenter-Business-Analysts Test Review

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

NEW QUESTION # 37
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. Transaction approval rules
- B. Authority Limits
- C. Claim Maturity Level - Ability to pay
- D. Financial holds

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 specific Validation 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 the amount of 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 suspend all payments (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 # 38

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

Answer: C

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 # 39
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. All claims must include both a police report and the details of any passengers in the vehicle, whether they sustained injuries or not.
- C. When the claim is created, we want to flag the claim with a reminder for the Adjuster to contact the insured.
- D. There should be reminders for the Adjuster to complete the following items for every new claim created: review any photographs of the accident.

Answer: D

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 everynew 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 aBusiness Ruleor 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 # 40

When creating a new Personal Auto claim, Succeed Insurance would like to identify when Rideshare is the primary use for a vehicle. A Business Analyst (BA) thinks that Primary Use already exists as a typekey on the Vehicle Details screen.
What are two ways the BA can confirm whether this field is configured in ClaimCenter and, if it is, which values are available in the typelist? (Choose two.)

* A. Open Guidewire Studio for ClaimCenter > Navigate to the Vehicle Details screen > Locate the Primary Use field to view its typelist.
* B. Access the Data Dictionary > Click the Data Entities link > Open the PrimaryUse entity from left-hand pane to view field details on the right pane.
* C. Log in to ClaimCenter > Create a new Personal Auto claim > Navigate to Vehicle Details > Use keyboard shortcut CTRL + F to find information about the fields on the screen.
* D. Access the Guidewire ClaimCenter Application Guide > Go to section on Personal Auto Object Model which lists available entities.

Answer: A,B

Explanation:
To verify the configuration of a specific field and its available values (typelist) within a specific implementation (like Succeed Insurance), a Business Analyst must consult the sources that reflect the current, actual system configuration, not just the out-of-the-box documentation.
* Option A (Data Dictionary):TheData Dictionaryis the definitive, generated documentation of the running application's data model. It lists allEntities(such as Vehicle) and theirTypekeys(such as PrimaryUse). By navigating to the Data Dictionary, a BA can confirm if the field exists in the database schema and view the specificTypelistvalues (e.g., "Rideshare", "Commuting", "Pleasure") associated with it. This is a primary tool for BAs to understand the data structure.
* Option D (Guidewire Studio):Guidewire Studiois the Integrated Development Environment (IDE) used to configure the application. It contains the "Source of Truth" for all configuration files. A BA (or a developer assisting them) can open thePage Configuration (PCF)files to see the Vehicle Details screen definition or open theTypelistfiles (.tti/.ttx) directly to see exactly which values are defined and active.
Why other options are incorrect:
* Option B (Application Guide):The Application Guide documents theBase (Out-of-the-Box)product features. It does not contain customer-specific customizations or extensions. If "Primary Use" or
"Rideshare" were added or modified by Succeed Insurance, the Application Guide would not reflect this.
* Option C (UI Inspection with CTRL+F):While logging into the application allows a user to see the dropdown on the screen, the shortcutCTRL + Fis merely the browser's "Find" function. It searches visible text on the page but does not provide configuration metadata, hidden values, or definitive proof of the underlying data model structure. The correct shortcut for inspecting widget properties in Guidewire is Alt + Shift + I (Location Info), but even that is less efficient for viewing a full typelist than the Data Dictionary or Studio.

NEW QUESTION # 41

Which workflow will kick in if the claim assignment is handled via "Default Group Claim Assignment Rule" with available matching?

* A. Claim goes to the "Root Group" for manual assignment.
* B. Claim gets assigned to a Supervisor to determine next step.
* C. Claim gets assigned to an appropriate Group based on geography and LOB.
* D. Claim gets assigned to a user based on expertise and workload.

Answer: D

Explanation:
In Guidewire ClaimCenter, assignment logic functions in a two-stage process: first Global Assignment (which finds the appropriate Group) and then Group Assignment (which finds the appropriate User within that group).
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TheDefault Group Claim Assignment Ruleis the specific logic set used to distribute claimswithina group once the group has already

been identified. When this rule is configured with "available matching" (often referred to as criteria-based or attribute-based assignment), the system evaluates the users inside that group against specific criteria.
* Workflow:The system filters the group's users to find those who are "available" (not on vacation) and then matches the claim against user attributes such asExpertise,Workload(current claim count), or specific skills.
* Result:The claim is automatically assigned to the best-fitUserwithin that group.
Why other options are incorrect:
* Option B (Geography/LOB):This describesGlobal Assignmentrules, which are responsible for routing the claim to the correct office or unit (Group), not the specific user.
* Option C (Supervisor):Assigning to a supervisor is a fallback mechanism (often called "Assign to Supervisor") used when the system fails to find a matching user or when manual intervention is explicitly required. It is not the primary function of "available matching."
* Option D (Root Group):Routing to the "Root Group" is a last-resort fallback when Global Assignment fails entirely to find any appropriate group.

NEW QUESTION # 42
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