# NY-Life-Accident-and-Health Study Test - NY-Life-Accident-and-Health Valid Exam Cram

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**PSI - NY Life, Accident and Health Practice Exam 17-55 (75 Questions - Actual Test 150 Questions) with 100% Correct Answers**

Which policy provision permits the policy owner to take a specified number of days to examine the contract, and allows for cancellation and a full refund if the policy owner rejects the terms or costs? - ANSWER-Free Look

When will a policy pay on a UCR basis? - ANSWER-When particular benefits are not listed on a payment schedule

Which type of rider reimburses health and social service expenses incurred in a convalescent or nursing home facility? - ANSWER-long term care rider

Which of the following is exempted from the incontestability provision in insurance policies? - ANSWER-Fraudulent misstatements

What does first dollar coverage mean? - ANSWER-As soon as covered medical expenses are incurred, the policy begins to pay

What is the waiver of premium provision? - ANSWER-In a long term care contract, the premium is waived after the insured has been confined for a specific period of time

According to the Time Payment of Claims provision, the insurer must make the payment immediately after receiving proof of loss EXCEPT - ANSWER-for claims involving periodic payments

Which is a disadvantage to a flexible premium annuity? - ANSWER-the actual amount of the annuity benefit cannot be determined in advance

When a policy or certificate containing an accelerated benefit provision is applied for or delivered, the producer is responsible for providing that applicant a summary of coverage that includes all of the following EXCEPT - ANSWER-a detailed and comprehensive summary of the accelerated benefit

which one of the following represents an advantage of obtaining a policy loan versus a withdrawal? - ANSWER-the loan is not taxed while a withdrawal is taxed for amounts above the contract cost basis

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## Insurance Licensing NY-Life-Accident-and-Health Exam Syllabus Topics:

| Section | Weight | Objectives |
|---|---|---|
| Insurance Regulation and General Principles | 20% | - Insurance Concepts<br>• 1. Risk Management and Insurable Interest<br>• 2. Contract Law and Policy Structure<br>- New York Insurance Code and Laws<br>• 1. Licensing Requirements and Procedures<br>• 2. Unfair Trade Practices<br>• 3. Producer Responsibilities and Ethics |

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| Accident and Health Insurance | 35% | - Policy Provisions and Claims<br>• 1. Eligibility and Enrollment<br>• 2. Coordination of Benefits<br>- Health Insurance Basics<br>• 1. Medical Expense and Disability Income<br>• 2. Group vs Individual Coverage<br>- Government Health Programs<br>• 1. Medicare and Medicaid<br>• 2. New York State Specific Programs |
| Life Insurance Products and Provisions | 30% | - Policy Provisions, Riders and Options<br>• 1. Non-forfeiture Values and Dividends<br>• 2. Beneficiary Designations<br>- Types of Life Insurance Policies<br>• 1. Term, Whole Life, Universal Life<br>• 2. Annuities and Retirement Products |
| Underwriting, Marketing and Sales Practices | 15% | - Sales and Customer Service<br>• 1. Suitability and Disclosure Requirements<br>- Application and Underwriting Procedures<br>• 1. Risk Classification and Selection |



## NY-Life-Accident-and-Health Valid Exam Cram, NY-Life-Accident-and-Health Reliable Braindumps Sheet

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## Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q110-Q115):

**NEW QUESTION # 110**
Long-term care policies MUST cover which of the following conditions?

- A. Acts of war while serving in the military.
- B. Alcoholism or drug addiction.
- C. Alzheimer's disease.
- D. Self-inflicted injuries.

**Answer: C**

Explanation:
Long-term care (LTC) insurance is intended to cover services needed when an insured cannot perform activities of daily living (ADLs) or suffers a cognitive impairment that requires substantial supervision for health and safety. A core regulatory and policy design principle is that LTC benefits must be available for qualifying impairments regardless of whether the cause is physical or

cognitive . Alzheimer's disease is a leading cause of cognitive impairment and is specifically recognized in LTC training materials as a condition LTC policies must cover when it results in the required level of functional or cognitive limitation. In practice, Alzheimer's often triggers eligibility through the cognitive impairment standard, even when the insured can still perform some ADLs, because supervision is needed to protect the individual from threats to health and safety.
The other options are commonly associated with policy exclusions rather than required coverage. LTC policies frequently exclude losses related to war or acts of war , and they may exclude intentionally self- inflicted injuries . Alcoholism or drug addiction is not treated as a mandatory covered condition in the same way; coverage depends on policy terms and is often limited or excluded.
Therefore, the condition LTC policies must cover is Alzheimer's disease .

**NEW QUESTION # 111**
In a health insurance policy, an insured has an out-of-pocket limit of $10,000, a deductible of $500, and an 80%/20% coinsurance. The insured incurs $50,000 of covered losses in an accident. How much will the insurer have to pay?

- A. $40,000
- B. $39,600
- C. $49,500
- D. $35,500

**Answer: B**

Explanation:
The correct answer is $39,600 . To determine the insurer's payment, the deductible and coinsurance provisions must be applied to the total covered medical expenses. First, the insured must pay the $500 deductible . Subtracting this amount from the total covered losses of $50,000 leaves $49,500 of eligible expenses subject to coinsurance.
Under an 80/20 coinsurance arrangement , the insurer pays 80% of the covered expenses and the insured pays 20% . Applying the insurer's portion to the remaining amount:
80% × $49,500 = $39,600 .
Therefore, the insurer's payment equals $39,600 , while the insured would pay the deductible plus their coinsurance share. Although the policy mentions a $10,000 out-of-pocket limit , the insured's cost in this situation (the $500 deductible plus 20% of the remaining expenses) does not exceed that limit , so the limit does not affect the calculation.
Thus, after applying the deductible and coinsurance provisions, the insurer pays $39,600 , making Option B the correct answer.

**NEW QUESTION # 112**
Predicting an individual ' s future earning potential and determining how much of that amount would be devoted to his dependents incorporates the

- A. loss exposure approach.
- B. human life value approach.
- C. salary projection approach.
- D. personal needs approach.

**Answer: B**

Explanation:
The correct answer is human life value approach . In life insurance planning, the human life value approach is used to estimate the economic value of an insured person's future earnings to those who depend on that income. It focuses on the idea that an individual's life has an insurable value based on the amount of income he or she is expected to earn in the future and the portion of that income that would have been used to support dependents. This method is commonly applied when determining how much life insurance is needed to replace the financial contribution of a wage earner.
Under this approach, factors such as current earnings, future earning capacity, years until retirement, inflation, taxes, and personal living expenses are considered. The amount available to dependents is then projected to help establish an appropriate death benefit.
The other options do not fit this definition. The needs approach centers on the survivors' financial needs after death, not strictly on future income value. "Loss exposure" and "salary projection" are not the standard life insurance need-analysis terms tested for this concept. Therefore, the correct answer is human life value approach .

**NEW QUESTION # 113**
Which of the following is a basic benefit of Medicare Supplemental insurance?

- A. First 3 pints of blood each year.
- B. Basic drugs limit of $1,250.
- C. Preventive care.
- D. At-home recovery.

**Answer: A**

Explanation:
Medicare Supplement insurance (Medigap) is designed to fill gaps in Original Medicare (Parts A and B) by paying certain out-of-pocket expenses that Medicare does not pay in full. A commonly tested basic Medigap benefit is coverage for the first 3 pints of blood each year . Under Original Medicare, a beneficiary may be responsible for the cost of the first three pints of blood in a calendar year (unless replaced or covered under specific circumstances). Medigap policies include this "first three pints" coverage as part of the standardized core benefits, helping reduce the beneficiary's exposure to unexpected hospital or outpatient blood costs.
The other choices are not considered standard "basic" Medigap benefits. "At-home recovery" and certain "preventive care" enhancements have been associated with limited or older plan designs rather than being universally basic. "Basic drugs limit of $1,250" reflects older outpatient prescription concepts that are largely associated with pre-Part D benefit structures and not a core Medigap basic benefit in the way the blood coverage is. Therefore, the correct basic benefit is the first 3 pints of blood each year .

**NEW QUESTION # 114**
Multiple policies that are rated for different communities and have substantially similar benefits as determined by the superintendent will be required to:

- A. merge plans
- B. pool experience
- C. change benefits
- D. refile rates

**Answer: B**

Explanation:
The correct answer is pool experience . Under New York insurance rating rules , when an insurer has multiple policies that are community rated in different communities but provide substantially similar benefits , the Superintendent may require the insurer to pool the experience of those policies. Pooling experience means combining the claims and loss experience of the similar policies for rating purposes rather than allowing the insurer to separate them in a way that could distort rates or create unfair differences among insured groups.
This requirement supports the regulatory goal of fair and consistent community rating . Community rating is intended to prevent insurers from charging significantly different premiums to similarly situated insureds based on claims experience or selective grouping. If substantially similar plans were kept artificially separate, it could undermine the integrity of the rating system. By requiring pooled experience, New York helps ensure that premiums more accurately reflect the combined risk of comparable policy forms.
The other options are incorrect because the regulation does not automatically require insurers to merge plans , change benefits , or refile rates as the principal action in this circumstance. The specific regulatory requirement tested here is to pool experience .

**NEW QUESTION # 115**
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