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Professional Proctored Exam Guide

ClaimCenter Business Analysts

This exam guide is designed to help you evaluate your readiness to successfully complete the Professional certification exam for ClaimCenter business analysts. It includes information about the target audience, required prerequisites, recommended training, and test topics. Guidewire recommends a mix of training, hands-on product experience, and knowledge of best practices to maximize your chances of success on this exam.

Target Audience

The Professional Certification - ClaimCenter Business Analyst - Jasper Proctored Exam is recommended for any business analyst who works with ClaimCenter as part of Guidewire InsuranceSuite or Digital implementations. This exam validates that business analysts can interpret a variety of ClaimCenter requirements effectively and efficiently. Those who pass this exam will become a *Certified Professional*, one of two certifications required for business analysts to earn the esteemed *Certified Ace* designation.

Why Certify?

Guidewire certifications allow learners to demonstrate increasing competency in their role. The *Certified Professional* designation is a coveted achievement that will help elevate you from the crowd. *Certified Professionals* are more productive, more self-sufficient, and more prepared to capture high-quality requirements that maximize product capabilities.

Certification Dependencies

Prerequisite Certifications

Business analysts do not need an existing Guidewire certification before they pursue the *Certified Professional* designation. Those who pass the Professional Certification - ClaimCenter Business Analyst - Jasper Proctored Exam will become a *Certified Professional* in the ClaimCenter business analyst track.

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Why Do You Need to Trust on TrainingQuiz Guidewire ClaimCenter-Business-Analysts Exam Questions?

As the development of the science and technology is fast, so the information of the ClaimCenter-Business-Analysts exam materials changes fast accordingly. The updated version of the ClaimCenter-Business-Analysts study guide will be different from the old version. Some details will be perfected and the system will be updated. You will enjoy learning on our ClaimCenter-Business-Analysts Exam Questions for its wonderful and latest design with the latest technologies applied.

Guidewire ClaimCenter-Business-Analysts Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> Claim Center Financials Transactions: This section covers financial controls including payment approvals and holds, contact and vendor management, service request handling, and security framework with permissions and access control lists.
Topic 2	<ul style="list-style-type: none"> 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 3	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 5	<ul style="list-style-type: none"> 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.

Guidewire ClaimCenter Business Analyst - Mammoth Proctored Exam Sample Questions (Q21-Q26):

NEW QUESTION # 21

A Business Analyst (BA) has identified a new typecode essential for Succeed Insurance implementation. During adjudication, Adjusters need to be able to update the loss cause value to reflect the new typecode. Which tabs in a Guidewire Story Card should be used to document the business requirement?

- A. Change Summary, UI Fields, Typelist, Action Items, and Business Acceptance
- B. Change Summary, UI Mockup, UI Fields, Typelist, and Action Items
- C. Document Control, UI Mockup, UI Fields, Typelist, and Business Acceptance**
- D. Document Control, UI Mockup, Typelist, Action Items, and Business Acceptance

Answer: C

Explanation:

To fully document a requirement that involves both a User Interface change (updating a value on a screen) and a Data Model change (adding a new typecode), the standard Guidewire Story Card tabs required are:

* Document Control: Captures the metadata (Author, Version, Owner) to track the requirement's history.

* UI Mockup: visually illustrates where on the screen the "Loss Cause" field is located and how the dropdown should appear to the Adjuster.

* UI Fields: Defines the specific behavior of the field (e.g., Is it mandatory? Is it editable during adjudication? What is the label?).

* Typelist: This is critical for this specific scenario. It lists the actual Code, Name, and Description of the new typecode being added to the "Loss Cause" typelist.

* Business Acceptance: Defines the testable criteria (Acceptance Criteria) to verify that the adjuster can successfully select the new value and save the claim.

Why Option B is correct: It is the only option that includes both the visual requirements (Mockup/Fields) and the data requirement (Typelist) alongside the standard control and testing tabs (Document Control/Business Acceptance).

NEW QUESTION # 22

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 low complexity auto claim, assigned to Midwest Low Complexity Auto Adjusters Group, with activity for vehicle inspection.
- B. The new claim will be segmented as mid-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 of 38 is significantly high. In standard configuration, high scores (typically indicating severe damage or total loss potential) trigger a High Complexity segmentation.

* Assignment (Geography): The accident occurred in Chicago (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 # 23

A claim for an auto accident in California has been assigned to an insurance Adjuster in the Midwest region for investigation and processing. The claim has been flagged as "Low Complexity" in ClaimCenter. The Adjuster has an authority limit for total reserves of \$30,000 and has created reserves totaling \$35,000.

What is the correct approval routing for this transaction?

- A. The transaction will require approval from another team member who has the authority limit to approve.
- B. The transaction will require approval from the Supervisor of the group.
- C. This transaction will not require approval because the claim is identified as low complexity.
- D. This transaction will require approval because the Adjuster does not work in the same region where the claim was reported.

Answer: B

Explanation:

Based on the Guidewire ClaimCenter Financials and Authority Limits documentation, the correct behavior for this scenario is determined by the strict enforcement of Authority Limits, regardless of claim complexity or geographic region.

In ClaimCenter, every user is assigned specific authority limits for various financial transactions, including reserves, payments, and recovery reserves. These limits are absolute constraints designed to control financial exposure. In the scenario provided, the Adjuster attempted to set a reserve of \$35,000, which exceeds their authorized limit of \$30,000.

When a user submits a financial transaction that exceeds their pre-configured authority limit, ClaimCenter automatically triggers an Approval Workflow. The system validates the transaction amount against the user's limit at the time of submission. Since the limit is breached, the transaction is not committed immediately to the database as "Submitted"; instead, it enters a "Pending Approval" status.

Routing Logic:

The standard, out-of-the-box approval routing logic in ClaimCenter follows the Group Hierarchy.

* The system identifies the group to which the Adjuster belongs.

* It creates an Approval Activity.

* This activity is assigned to the Supervisor of that group.

The Supervisor must then review the transaction. If the Supervisor has sufficient authority (greater than \$35,000), they can approve it. If the Supervisor also lacks sufficient authority, they must still "approve" it to escalate the request further up the hierarchy to the manager, until it reaches a user with sufficient limits.

Why other options are incorrect:

* A (Complexity): Claim complexity flags (e.g., "Low Complexity") are often used for Assignment rules (Segment-based assignment) or straight-through processing of documents, but they do not override Financial Authority controls. A low-complexity claim still requires financial oversight if the dollar amount is high.

* B (Peer Approval): Approval routing is hierarchical, not peer-to-peer. It does not look for "any" team member; it looks specifically for the defined Supervisor.

* C (Region): The region mismatch might trigger an assignment rule or a validation warning depending on configuration, but the specific trigger for the approval here is purely the financial discrepancy (\$35k > \$30k), not the geography.

NEW QUESTION # 24

Satisfied with the outcome of a Requirements Workshop, a Business Analyst (BA) attributed the success to preparation. The assigned task had been to document the requirements for capturing details on vehicle incidents for Personal Auto.

* Before the session, the BA reviewed ClaimCenter functionality by creating a new Personal Auto Claim involving physical damage to a vehicle.

* During review, the BA saw that ClaimCenter did not have a graphical representation of a vehicle with clickable hot spots to identify the damage areas like they have in their current application.

* Upon further research, the BA found that Guidewire does offer this functionality and even provides a Graphical Incident Capture Accelerator to ease implementation.

* During the workshop, the BA was able to clearly present all options for capturing vehicle incident details. Instead of having to develop the Vehicle Incident Capture functionality from scratch, the team was able to make a quick decision to add this functionality and end the meeting 30 minutes early.

Which two outcomes demonstrate the importance of preparing for a Requirements Workshop by becoming familiar with the features and functionality of ClaimCenter? (Choose two.)

- A. The BA was able to make decisions in advance about where gaps existed and where changes were needed.
- **B. The BA prevented the team from rebuilding something in a less effective way.**
- C. The BA was able to gain team acceptance of the base product process instead of the legacy system process.
- **D. The BA was able to compare their legacy process to how ClaimCenter handles the same business process.**

Answer: B,D

Explanation:

This scenario highlights the value of Feature Knowledge and Gap Analysis during preparation.

* Prevention of unnecessary work (Option A): Because the BA researched and found the "Graphical Incident Capture Accelerator," the team avoided the costly mistake of deciding to "develop the... functionality from scratch." This is a direct outcome of the BA's preparation preventing an inefficient custom build.

* Comparison of Legacy vs. New (Option B): The text details that the BA "reviewed ClaimCenter functionality" and explicitly noted the difference ("saw that ClaimCenter did not have... like they have in their current application"). This ability to articulate the gap between the As-Is (Legacy) and the To-Be (Base ClaimCenter) allowed the BA to present the Accelerator as the perfect bridge solution.

Why other options are incorrect:

* Option C: The team did not accept the "base product process" (which lacked the graphics); they accepted the Accelerator (an add-on) to match the legacy expectation of clickable hot spots.

* Option D: The decision was not made "in advance." The text states the team made the "quick decision" during the workshop. The preparation enabled the team's decision, but the BA did not make it unilaterally beforehand.

NEW QUESTION # 25

An Adjuster at Succeed Insurance creates a check with a partial payment of \$1,200 for medical expenses payable to a claimant who was injured in a collision. The check has completed the following processing steps:

. The payment exceeded the Adjuster's authority limits, changing the status to Pending Approval.
 . The Adjuster's supervisor reviewed and approved the payment, changing the status to Awaiting Submission.
 . A batch process sent the check to the external check processing system, changing the status to Requested when ClaimCenter received an update from the external system.
 The Adjuster received new information indicating that the check amount should be reduced to \$950.
 Which action should the Adjuster take?

- A. Edit the check and change the amount, then submit it for processing.
- **B. Void the check and create a new check for the correct amount.**
- C. Ask the bank to hold the check and create a new check for the correct amount.
- D. Stop the check and create a new check for the correct amount.

Answer: B

Explanation:

250 to 350 words From Exact Extract of Guidewire ClaimCenter Business Analyst documentation:

In the lifecycle of a check within Guidewire ClaimCenter, the Requested status indicates that the payment instruction has been successfully handed off to the downstream check writing or electronic funds transfer system. Once a check reaches this status, it is considered a committed financial transaction and is locked from further editing.

* Why Option A is incorrect: You cannot edit a check that is in "Requested" status. The "Edit" button will likely be disabled or the fields locked because the data has already left the system.

* Why Option C is incorrect: A "Stop" payment is typically reserved for scenarios where a physical check has been lost, stolen, or destroyed after it was printed and mailed. While a Stop Payment does prevent the check from being cashed, it is a specific banking process often involving fees.

* Why Option D is Correct: To correct an administrative error (such as the wrong amount) for a check that has been processed but not yet negotiated (cashied), the standard procedure is to Void the check.

Voiding the check in ClaimCenter performs two critical functions:

* It reverses the financial T-accounts (reserves and payments) associated with the transaction, ensuring the claim financials are accurate.

* It updates the status to "Voided," effectively cancelling the payment in the system.

After voiding the incorrect check (\$1,200), the Adjuster must then create a new check for the correct amount (\$950) to pay the claimant.

NEW QUESTION # 26

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