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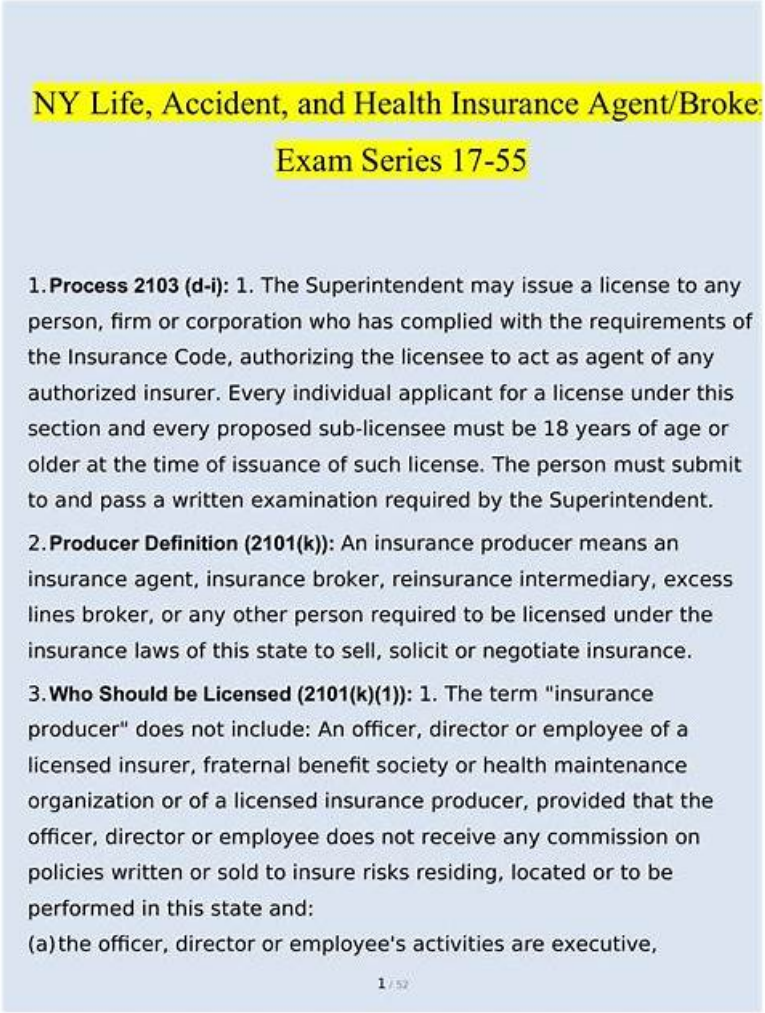
NY Life, Accident, and Health Insurance Agent/Broke

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 NY-Life-Accident-and-Health Exam Syllabus Topics:

Section	Weight	Objectives

Topic 1: New York State Regulations	20-25%	- Fiduciary responsibilities - Replacement and churn rules - Licensing requirements and procedures - Advertising regulations - NYS Insurance Law requirements - Consumer protection regulations
Topic 2: Life Insurance Fundamentals	25-30%	- Policy riders and endorsements - Beneficiary designations - Dividends and nonforfeiture options - Policy types and provisions - Policy reinstatement
Topic 3: General Insurance Principles	15-20%	- Agent/broker duties and ethics - Underwriting principles - Ethical sales practices - Insurance contract fundamentals - Fair claims settlement practices
Topic 4: Accident and Health Insurance	25-30%	- Major medical coverage - Disability income insurance - Long-term care insurance basics - Medical expense coverage - Dental and vision insurance basics - Health insurance policy types (individual, group, HMOs)

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Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q48-Q53):

NEW QUESTION # 48
The cost of a long-term care policy is based on all of the following EXCEPT

- A. health condition.
- B. age.
- C. level of benefits provided.
- D. personal income.

Answer: D

Explanation:
The correct answer is D. personal income. The premium for a long-term care (LTC) insurance policy is determined primarily by underwriting and policy design factors rather than the applicant's income level.
Insurers evaluate several key elements when calculating the cost of coverage. One major factor is the applicant's age at the time of purchase, because the probability of needing long-term care services increases as a person gets older. Another important factor is the applicant's health condition, since insurers evaluate medical history and current health status to assess the likelihood of future claims.

The level of benefits provided is also a significant pricing factor. Policy features such as the daily benefit amount, benefit period, elimination period, inflation protection, and optional riders all affect the overall premium cost. Higher benefit levels and broader coverage typically result in higher premiums.
However, personal income is not used to determine the cost of a long-term care insurance policy. While income may influence whether an individual can afford a policy or qualifies for certain financial assistance programs, it is not a rating factor used to calculate LTC premiums. Therefore, the correct answer is personal income.

NEW QUESTION # 49
In broad terms, the types of support and services generally associated with Long-Term Care policies are provided at which three levels of care?

- A. Skilled nursing, Intermediate, and custodial care.
- B. Professional, social, and economic care.
- C. Functional, rehabilitational, and medical care.
- D. Home-based, assisted living, and medical care.

Answer: A

Explanation:
The correct answer is D. Skilled nursing, Intermediate, and custodial care. Long-Term Care insurance is designed to help cover ongoing care for individuals who cannot fully care for themselves because of chronic illness, disability, cognitive impairment, or the inability to perform activities of daily living. In traditional insurance licensing materials, long-term care services are commonly described as being delivered at three broad levels: skilled nursing care , intermediate care , and custodial care .
Skilled nursing care is the highest level and involves medically necessary services performed by licensed medical personnel under a doctor's supervision. Intermediate care is less intensive than skilled nursing care but still involves professional oversight and some medical or rehabilitative support. Custodial care provides assistance with personal needs such as bathing, dressing, eating, and moving about, and it is the type of care most commonly associated with long-term care claims.
The other answer choices do not reflect the standard three recognized levels used in long-term care insurance terminology.
Therefore, the broad categories of care generally associated with Long-Term Care policies are skilled nursing, intermediate, and custodial care .

NEW QUESTION # 50
The statement, " Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty... " MUST appear in all New York

- A. applications for insurance and on all claim forms.
- B. insurance documents distributed to the general public.
- C. applications for credit.
- D. insurance communications with consumers.

Answer: A

Explanation:
The correct answer is applications for insurance and on all claim forms . Under New York insurance law , insurers are required to include a fraud warning statement on certain insurance documents to help prevent fraudulent insurance activities. This warning informs applicants and claimants that knowingly providing false information or concealing material facts for the purpose of misleading an insurer constitutes insurance fraud , which is a criminal offense and may also lead to civil penalties.
The regulation specifically requires that this fraud notice appear on all insurance applications and claim forms used within the state. The purpose is to ensure that individuals are clearly informed of the legal consequences of submitting false information when applying for insurance coverage or when filing a claim. By placing the warning directly on these documents, New York aims to discourage fraudulent behavior and strengthen compliance with insurance regulations.
The other options are incorrect because the fraud warning requirement does not apply broadly to general insurance communications, public documents, or credit applications. Instead, the law targets the two most critical documents where fraud might occur-insurance applications and claim forms .

NEW QUESTION # 51
The difference between the face value of a life insurance policy and its cash value is the

- A. term value.
- B. net amount.
- C. market value.
- D. assumed amount.

Answer: B

Explanation:
The correct answer is C. net amount. In life insurance, the difference between a policy's face amount and its cash value is commonly referred to in licensing terminology as the net amount at risk , and exam questions often shorten that phrase to net amount . This represents the portion of the death benefit the insurer is actually risking at a given time because the cash value already belongs to the policyowner and offsets part of the insurer's exposure. As cash value increases over the life of a permanent policy, the insurer's net amount at risk generally decreases. NAIC life insurance regulatory material describes the amount subtracted from the policy's face value to determine the net amount at risk , which is consistent with this concept. (NAIC) The other options are not correct insurance terms for this relationship. Market value applies more to investments or securities. Assumed amount is not the standard term used in life insurance contract analysis.
Term value is also incorrect because term insurance generally does not build cash value. Therefore, the recognized answer is net amount , meaning the policy's net amount at risk . (NAIC)

NEW QUESTION # 52
Which of the following is described when a selected group of practitioners, in a certain area, agrees to provide services at a pre-arranged cost on a fee-for-service basis?

- A. preferred provider organization
- B. indemnity organization
- C. coalition group
- D. risk purchasing group

Answer: A

Explanation:
The correct answer is A. preferred provider organization. A Preferred Provider Organization (PPO) is a health care arrangement in which an insurer or plan contracts with a selected network of doctors, hospitals, and other providers in a geographic area to deliver medical services at negotiated or reduced charges . Federal and New York sources describe PPOs as networks of participating providers that agree to furnish care at discounted rates, while patients generally retain the flexibility to use non-network providers at a higher cost. That matches the question's description of a selected group of practitioners agreeing to provide services at a pre-arranged cost on a fee-for-service basis . (HealthCare.gov) The other options do not fit this definition. An indemnity organization traditionally reimburses covered losses and does not depend on a contracted provider network with prearranged fees. A risk purchasing group is associated with liability insurance purchasing arrangements, not standard health provider networks. Coalition group is not the recognized term for this managed care structure. Therefore, the correct description is a preferred provider organization . (Department of Financial Services)

NEW QUESTION # 53
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