

Exam Questions for the Insurance Licensing NY-Life-Accident-and-Health - Master Your Certification Journey

NYS Life, accident, and health insurance

Exam

1. Which type of life insurance policy is best suited for paying off the outstanding balance of a 30-year mortgage in the event of the insured's death?

ANS 30-year decreasing term.

2. How many days notice does the ACA require insurers to give before rescinding coverage?

ANS 30

3. A signed good health statement may be requested by a life producer at the time of

ANS Policy Delivery

4. Carol purchases a whole life policy that provides a choice of dividend options. This policy is required to include a statement that the dividends are

ANS Not Guaranteed

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

Section	Objectives

Accident and Health Insurance	- Policy features and provisions • 1. Elimination periods and benefit limits • 2. Coordination of benefits - Health insurance products • 1. Disability income insurance • 2. Hospital and medical expense coverage
Insurance Fundamentals	- Insurance contract law basics • 1. Policy provisions and clauses • 2. Elements of a valid contract - Principles of insurance and risk management • 1. Risk classification and pooling of risk • 2. Insurable interest and indemnity concepts
State Regulations (New York)	- Licensing requirements • 1. Pre-licensing education requirements • 2. Application and background checks - Ethics and compliance • 1. Unfair trade practices • 2. Producer responsibilities and conduct

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Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q92-Q97):

NEW QUESTION # 92

Which of the following services must be provided by a health benefit plan issued on or after January 1, 2014?

- A. Long-term care services.
- B. Preventive health services.
- C. Adult dental care services.
- D. Adult eye care services.

Answer: B

Explanation:

The correct answer is D. Preventive health services. Health benefit plans issued on or after January 1, 2014 became subject to the Affordable Care Act's essential health benefit and preventive-service requirements for non-grandfathered coverage in the individual and small-group markets. Those rules require coverage for specified preventive services without cost-sharing when provided in accordance with federal guidelines. New York's post-2014 marketplace coverage materials likewise explain that plans must include the ACA's required essential health benefits, which include preventive and wellness services.

The other options are not the mandatory general requirement described in this question. Adult eye care and adult dental care are not universally required as core benefits in the same way preventive services are; the ACA's pediatric services category specifically includes pediatric vision and dental, not broad adult routine vision or dental as mandatory across all such plans. Long-term care services are also not one of the essential health benefits that every post-2014 health benefit plan must provide. Therefore, among the choices given, the service that must be provided is preventive health services

NEW QUESTION # 93

With respect to small group health benefit plans, a carrier may discontinue coverage or may refuse to renew such a plan if the employer

- A. has a supplemental plan with a competing carrier.
- B. employs fewer than 15 full-time employees.
- C. falls to pay the premium prior to the end of the grace period.
- D. has filed for bankruptcy in the prior year.

Answer: C

Explanation:

Under New York small group health benefit plan rules, carriers generally must renew coverage for an employer group, but there are specific exceptions where a carrier is permitted to discontinue or refuse renewal

. One of the primary permitted reasons is nonpayment of premium -if the employer does not pay required premiums within the policy's allowed timeframes (including any required grace period), the carrier may terminate or nonrenew coverage because the group is no longer meeting the contractual payment obligation.

The other options do not typically qualify as valid statutory reasons for nonrenewal in the small group market.

Merely employing fewer than 15 full-time employees is not a trigger for termination (small group status is based on employer size definitions, but size alone doesn't justify cancellation). Filing for bankruptcy is not, by itself, a standard guaranteed-renewability exception. Having supplemental coverage with another carrier also does not allow a carrier to cancel, because employers may coordinate coverage arrangements. Therefore, the only option that matches an allowed discontinuance/nonrenewal basis is failure to pay premiums before the end of the grace period .

NEW QUESTION # 94

Group long-term disability benefit amounts are usually limited to what percentage of the participant ' s income?

- A. 0
- B. 1
- C. 2
- D. 3

Answer: C

Explanation:

Group long-term disability (LTD) insurance is designed to replace a portion of an employee's income when a disabling sickness or injury prevents the employee from working for an extended period. Because disability benefits are intended to reduce financial hardship while also discouraging overinsurance (where someone could receive more income disabled than working), group LTD plans typically set benefits as a percentage of pre-disability earnings . In standard A & H licensing materials, the most common benefit level used in group LTD is 60% of the participant's income , often expressed as 60% of gross monthly earnings (sometimes coordinated with other income benefits and subject to a maximum monthly cap).

This 60% level is commonly used because it balances meaningful income replacement with the fact that certain work-related expenses may decrease during disability, and because taxes may affect net take-home pay depending on who paid the premium (employer vs. employee). Higher percentages like 80% or 100% are generally not typical for group LTD due to moral hazard concerns and plan design limits, while 40% is more common in some short-term disability arrangements or minimal designs.

Therefore, the usual limit is 60% .

NEW QUESTION # 95

Some states have laws ensuring that health insurance coverages are available at a reasonable cost and under reasonable conditions for small employers. Small employers are defined as having no more than

- A. 75 employees.
- **B. 100 employees.**
- C. 200 employees.
- D. 150 employees.

Answer: B

Explanation:

The correct answer is 100 employees . In accident and health insurance licensing material, "small employer" or "small group" generally refers to an employer with 1 to 100 employees for purposes of small-group health insurance market rules. These laws are intended to make coverage more available and affordable for smaller businesses that may not have the bargaining power of large employers. They are commonly associated with protections involving availability of coverage, renewal standards, rating limitations, and fair underwriting conditions in the small-group market.

This question tests recognition of the standard upper limit used in modern health insurance regulation for a small employer group. The other options-75, 150, and 200-do not match the commonly tested definition.

In exam context, the purpose is to distinguish small-group health coverage from large-group coverage, because different rules may apply to eligibility, premium determination, and mandated access. So, when a health insurance question asks how many employees a "small employer" may have under these types of laws, the expected answer is no more than 100 employees .

NEW QUESTION # 96

Intentionally withholding information that should be provided to an insurer is known as

- **A. concealment.**
- B. twisting.
- C. estoppel.
- D. remission.

Answer: A

Explanation:

The correct answer is A. concealment . In insurance, concealment means an applicant or insured intentionally fails to disclose a material fact that should be made known to the insurer. A material fact is any information that would affect the insurer's decision to issue the policy, set the premium, or determine the scope of coverage. Because insurers rely on full and truthful disclosure during underwriting, concealment can be treated as a form of misrepresentation and may give the insurer grounds to deny a claim or rescind the policy, depending on the circumstances and applicable law.

The other choices do not match this definition. Estoppel is a legal principle that can prevent a party from asserting a right when its own actions have caused another to rely to their detriment. Remission is not the standard insurance term for withholding information in underwriting. Twisting is an unfair trade practice involving inducing a policyowner to replace existing insurance using misleading comparisons. Since the question asks specifically about intentionally withholding information from an insurer, the correct term is concealment .

NEW QUESTION # 97

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