

Insurance Licensing Realistic Practice NY-Life-Accident-and-Health Online 100% Pass Quiz

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 New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q12-Q17):

NEW QUESTION # 12

Clark will be doing business as an agent. When MUST he be appointed by the insurer?

- A. Within 20 days after commissions have been paid.
- **B. Within 15 days of signing the agency contract.**
- C. Within 15 days of submitting his license application.
- D. At the time the license application is submitted.

Answer: B

NEW QUESTION # 13

According to Health Insurance Portability and Accountability Act (HIPAA), when can a group health policy renewal be denied?

- A. There have been too many claims in the previous year.
- B. Participation or contribution rules have been changed.
- C. The size of the group has increased by more than 10%.
- **D. Participation or contribution rules have been violated.**

Answer: D

Explanation:

The correct answer is Participation or contribution rules have been violated . Under the Health Insurance Portability and Accountability Act (HIPAA), group health insurance plans are generally subject to guaranteed renewability requirements . This means that insurers must typically renew group coverage at the option of the employer or plan sponsor. However, HIPAA provides a few limited exceptions where renewal may legally be denied.

One of these exceptions occurs when the employer or group policyholder fails to comply with the insurer's participation or employer contribution requirements . Participation rules usually require a minimum percentage of eligible employees to enroll in the plan, while contribution rules require the employer to pay a specified portion of the premium. If the employer fails to meet these requirements or violates the contractual conditions, the insurer may have grounds to deny renewal of the group policy .

The other choices are incorrect. HIPAA does not allow insurers to deny renewal simply because the group had high claims experience , because the group size increased , or because contribution rules were changed . The critical factor is violation of participation or contribution requirements , making Option C the correct answer.

NEW QUESTION # 14

Which of the following is a life insurance contract written on the life of an individual?

- A. Survivorship Policy.
- B. Joint Life Contract.
- C. Insurance.
- **D. Single-Life Insurance.**

Answer: D

Explanation:

The correct answer is D. Single-Life Insurance. A single-life insurance policy is a contract that covers one individual only . The death benefit is paid when that one insured person dies, provided the policy is in force.

This is the most basic and common form of life insurance coverage and is used when protection is needed on the life of one person,

such as a wage earner, business owner, or parent. Because the contract is based on only one insured life, underwriting, premium calculation, and benefit payment are all tied to that single person's age, health, and policy terms.

The other choices are incorrect. A. Insurance is too broad and is not a specific type of life insurance contract.

B). Survivorship Policy covers two lives and typically pays upon the second death, not on a single individual alone. C. Joint Life Contract also covers two people, usually paying on the first death. Since the question asks for a policy written on the life of an individual, the proper term is Single-Life Insurance.

NEW QUESTION # 15

An insured owns a whole life policy that has accumulated cash value. Which of the following statements is true about the policy's cash value?

- A. It is subject to fluctuations of the company's overall performance.
- B. The cash value is not guaranteed.
- C. The policy's cash value is viewed as investment growth and therefore subject to taxation for each calendar year.
- **D. The growth of the policy's cash value is not subject to income tax while the policy is in force.**

Answer: D

Explanation:

The correct answer is B. The growth of the policy's cash value is not subject to income tax while the policy is in force. Whole life insurance is a form of cash value life insurance. As premiums are paid, part of the premium funds the death benefit and expenses, while part builds cash value inside the policy. Under standard life insurance taxation principles, that internal cash value buildup generally grows on a tax-deferred basis, meaning it is not taxed annually while it remains within the policy. The NAIC explains that whole life policies build cash value over time and that this value grows without being taxed currently, and IRS guidance similarly distinguishes taxable situations from ordinary in-force policy growth.

The other choices are incorrect. A is wrong because whole life cash value is not normally taxed each calendar year. C is more characteristic of variable life, where values fluctuate with investment performance. D is incorrect because traditional whole life generally provides guaranteed minimum cash values under the contract, subject to policy terms and continued premium payment; New York DFS whole life product guidance reflects that whole life operates on a guaranteed basis and includes cash surrender value provisions.

NEW QUESTION # 16

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. At-home recovery.
- D. Preventive care.

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 # 17

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