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## Guidewire ClaimCenter-Business-Analysts Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> <li>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.</li> </ul>
Topic 2	<ul style="list-style-type: none"> <li>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.</li> </ul>
Topic 3	<ul style="list-style-type: none"> <li>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.</li> </ul>
Topic 4	<ul style="list-style-type: none"> <li>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.</li> </ul>

## Pass Guaranteed Guidewire - ClaimCenter-Business-Analysts - ClaimCenter Business Analyst - Mammoth Proctored Exam –Reliable Preparation Store

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### Guidewire ClaimCenter Business Analyst - Mammoth Proctored Exam Sample Questions (Q10-Q15):

#### NEW QUESTION # 10

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. Stop the check and create a new check for the correct amount.
- D. Ask the bank to hold 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 (cash), 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 # 11

Succeed Insurance has a strategic initiative to offer pay-as-you-drive personal auto insurance to compete with other large carriers.

Customers who choose these policies must either own a vehicle that is equipped with a monitoring device or agree to install a device provided by Succeed. The monitoring device collects information about how the drivers of a covered vehicle drive, including how fast they drive, how hard they brake, and how many miles/kilometers the vehicle travels within a policy period.

This information is logged, and premiums are based on how the insured's driving behavior is categorized.

When a claim is reported, the log files must be obtained in order to

analyze the information captured by the monitoring device at the time of the incident.

Succeed plans to collect and evaluate the Vehicle Monitoring Log files in the first implementation phase, which is scheduled for release in 60 days. The project sponsors have instructed the implementation team to use base product functionality over customization. Integration should be leveraged where possible to avoid manual data entry.

The New Claim Wizard must capture whether or not the vehicle has a monitoring device installed when a personal auto claim is created against a pay-as-you-drive policy.

Which feature of the base product enforces this claim creation requirement?

- A. Create a Validation rule enforcing the Load and save validation level.
- B. Create a Validation rule enforcing a new custom Validation level for mechanical requirements.
- C. Create a Validation rule enforcing the Ability to pay validation level.
- **D. Create a Validation rule enforcing the New loss completion validation level.**

**Answer: D**

Explanation:

In Guidewire ClaimCenter, Validation Rules are used to enforce data integrity and business requirements at specific stages of the claim lifecycle. These stages are defined by Validation Levels.

\* New Loss Completion (Option B): This validation level is specifically designed as the "gatekeeper" for the New Claim Wizard (FNOL). Rules triggered at this level run when the user attempts to click

"Finish" to submit the new claim. If a rule fails (e.g., "If Policy Type = Pay-as-you-drive AND Monitoring Device is Null"), the system prevents the claim from being created and highlights the missing field. This directly meets the requirement to enforce data capture "when a personal auto claim is created." Why other options are incorrect:

\* Ability to Pay (A): This level runs when a user tries to issue a check. Using this would allow the claim to be created without the device info, only blocking the user later when they try to pay, which is too late for the requirement.

\* Custom Level (C): Creating custom levels is possible but discouraged when a standard level fits the purpose, aligning with the "use base product functionality" principle.

\* Load and Save (D): This level runs every time the claim is saved (even as a draft). Enforcing mandatory fields here can frustrate users who need to save their work partially complete.

## NEW QUESTION # 12

Which two actions may the Business Analyst (BA) perform based on the roles and permissions functionality of ClaimCenter? (Choose two.)

- A. Establish a best practice which dictates that each user should be given unique permissions to increase the precision of security
- **B. Create a collection of permissions to simplify the management of large groups of users with the same permissions**
- C. Design requirements around different authority limits within the customer's organization
- **D. Define a role that consolidates variable permissions across multiple users into a single set of permissions**

**Answer: B,D**

Explanation:

The Roles and Permissions functionality (part of the Role-Based Access Control or RBAC model) in ClaimCenter is designed to simplify security administration. A Business Analyst utilizes this functionality to define how users access the system.

\* Defining Roles (Option A): A "Role" in Guidewire is fundamentally a named container for a set of System Permissions (e.g., claimview, activitycreate). The BA defines a role (like "Adjuster" or

"Supervisor") by consolidating the necessary individual permissions into one single set.

\* Simplifying Management (Option B): The primary benefit of this model is efficiency. Instead of assigning 50 individual permissions to 100 different users, the BA/Admin creates a "Collection of permissions" (the Role) and assigns that single Role to the group of users. This simplifies onboarding and maintenance.

Why other options are incorrect:

\* Authority Limits (C): While related to security, Authority Limits (financial caps on reserves/payments) are technically distinct from "Roles and Permissions" functionality in the ClaimCenter object model.

Authority is handled via Authority Profiles, whereas Roles handle system access rights.

\* Unique Permissions (D): This is the opposite of best practice. Assigning unique permissions to every user creates a maintenance nightmare. The best practice is to use standard Roles.

## NEW QUESTION # 13

Which workflow will kick in if the claim assignment is handled via "Default Group Claim Assignment Rule" with available matching?

- A. Claim gets assigned to a Supervisor to determine next step.
- **B. Claim gets assigned to a user based on expertise and workload.**
- C. Claim gets assigned to an appropriate Group based on geography and LOB.
- D. Claim goes to the "Root Group" for manual assignment.

**Answer: B**

Explanation:

In Guidewire ClaimCenter, assignment logic functions in a two-stage process: first Global Assignment (which finds the appropriate Group) and then Group Assignment (which finds the appropriate User within that group).

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The Default Group Claim Assignment Rule is the specific logic set used to distribute claims within a group once the group has already been identified. When this rule is configured with "available matching" (often referred to as criteria-based or attribute-based assignment), the system evaluates the users inside that group against specific criteria.

\* Workflow: The system filters the group's users to find those who are "available" (not on vacation) and then matches the claim against user attributes such as Expertise, Workload (current claim count), or specific skills.

\* Result: The claim is automatically assigned to the best-fit User within that group.

Why other options are incorrect:

\* Option B (Geography/LOB): This describes Global Assignment rules, which are responsible for routing the claim to the correct office or unit (Group), not the specific user.

\* Option C (Supervisor): Assigning to a supervisor is a fallback mechanism (often called "Assign to Supervisor") used when the system fails to find a matching user or when manual intervention is explicitly required. It is not the primary function of "available matching."

\* Option D (Root Group): Routing to the "Root Group" is a last-resort fallback when Global Assignment fails entirely to find any appropriate group.

#### NEW QUESTION # 14

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 mid-complexity auto claim, assigned to Midwest Low Complexity Auto Adjusters Group, with activity for vehicle inspection.
- B. The new claim will be segmented as low 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 a Supervisor for further determination on next steps due to complexity.
- **D. The new claim will be segmented as high complexity auto claim, assigned to Midwest Complex Auto Adjusters Group, with activity for vehicle inspection.**

**Answer: D**

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 # 15

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