

NY-Life-Accident-and-Health Latest Exam Format, NY-Life-Accident-and-Health Test Questions Fee

PSI - NY Life, Accident and Health Practice Exam 17-55 (75 Questions - Actual Test 150 Questions) with 100% Correct Answers

Which policy provision permits the policy owner to take a specified number of days to examine the contract, and allows for cancellation and a full refund if the policy owner rejects the terms or costs? - ANSWER-Free Look

When will a policy pay on a UCR basis? - ANSWER-When particular benefits are not listed on a payment schedule

Which type of rider reimburses health and social service expenses incurred in a convalescent or nursing home facility? - ANSWER-long term care rider

Which of the following is exempted from the incontestability provision in insurance policies? - ANSWER-Fraudulent misstatements

What does first dollar coverage mean? - ANSWER-As soon as covered medical expenses are incurred, the policy begins to pay

What is the waiver of premium provision? - ANSWER-In a long term care contract, the premium is waived after the insured has been confined for a specific period of time

According to the Time Payment of Claims provision, the insurer must make the payment immediately after receiving proof of loss EXCEPT - ANSWER-for claims involving periodic payments

Which is a disadvantage to a flexible premium annuity? - ANSWER-the actual amount of the annuity benefit cannot be determined in advance

When a policy or certificate containing an accelerated benefit provision is applied for or delivered, the producer is responsible for providing that applicant a summary of coverage that includes all of the following EXCEPT - ANSWER-a detailed and comprehensive summary of the accelerated benefit

which one of the following represents an advantage of obtaining a policy loan versus a withdrawal? - ANSWER-the loan is not taxed while a withdrawal is taxed for amounts above the contract cost basis

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Insurance Licensing New York Life, Accident and Health Insurance Agent/Broker Examination Series 17-55 Sample Questions (Q38-Q43):

NEW QUESTION # 38

The Health Insurance Portability and Accountability Act (HIPAA) ensures that qualified individuals who change jobs will have access to group health insurance with their new employer without

- A. having any increase in premium costs.
- B. having to meet a new deductible.
- C. any change in the level of benefits they receive.
- **D. having to satisfy a new preexisting condition period.**

Answer: D

Explanation:

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted to improve the portability and continuity of health insurance coverage for employees and their dependents when they change or lose jobs. One of the key protections provided by HIPAA is that individuals moving from one group health plan to another may receive credit for prior continuous health coverage . This means that the time a person was previously insured under a group health plan is applied toward any preexisting condition exclusion period under the new employer's plan.

As a result, qualified individuals who maintain continuous coverage generally do not have to satisfy a new preexisting condition waiting period when enrolling in a new group health insurance plan. This provision prevents employees from losing coverage for medical conditions that existed before joining the new plan.

However, HIPAA does not guarantee that premiums will remain the same , nor does it prevent changes in deductibles or benefit levels, since these factors depend on the design of the employer's health plan. The primary objective of HIPAA is portability of coverage and protection against new preexisting condition exclusions when changing employment.

NEW QUESTION # 39

With respect to a life settlement contract, no person shall directly or indirectly pay a referral or finders fee to any person other than the

- A. owner ' s physician.
- B. owner ' s accountant.
- **C. life settlement broker.**
- D. insurance consultant.

Answer: C

Explanation:

The correct answer is life settlement broker . Under New York Insurance Law Article 78 , the life settlement rules prohibit paying a referral or finder's fee to most persons connected with the policyowner, including the owner's physician, attorney, accountant, insurance producer, insurance consultant, or other person providing medical, legal, or financial planning services . The statute specifically states that such compensation may not be paid to any of those persons, or to any other person representing the owner, other than a life settlement broker .

This rule is designed to prevent conflicts of interest and to ensure that recommendations about life settlements are not improperly influenced by side compensation. New York permits compensation only where it is paid in connection with the role of a licensed life settlement broker , because that person is regulated under the state's life settlement framework. The broker is the recognized professional authorized to represent the owner in the transaction and receive compensation in that capacity.

NEW QUESTION # 40

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

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

Answer: A

Explanation:

The correct answer is B. Within 15 days of signing the agency contract. In New York, when an insurer authorizes a licensed insurance producer to act as its agent, the insurer must make the formal appointment within the time required by state insurance law. The appointment is tied to the establishment of the agency relationship, which begins when the insurer and the producer enter into the agency contract. New York licensing rules require the insurer to notify the state of that appointment within the required 15-day period.

The other choices are incorrect because appointment is not based on the date the producer submits a license application, and it does not have to occur at the exact same moment the license application is filed. It is also unrelated to the timing of commission payments. The appointment requirement exists so the state can identify which insurers a producer is authorized to represent as an agent. Therefore, once Clark signs the agency agreement and is authorized to act on behalf of the insurer, the insurer must complete the appointment process within 15 days of signing the agency contract.

NEW QUESTION # 41

What information must be included in the statement accompanying an insurance claim payment made by an insurer?

- A. The coverage under which the payment is being made
- B. The reinsurance carrier involved
- C. The agent's name and address
- D. A list of all claimants involved

Answer: A

Explanation:

When an insurer issues a claim payment, New York claims-handling standards require that the payment be accompanied by an explanation that clearly identifies what the payment represents. A key required item is the coverage under which the payment is being made, so the claimant (or insured) can understand the basis for the payment and how it relates to the policy's benefits. This helps avoid confusion when a policy includes multiple coverages, benefit limits, deductibles, copayments/coinsurance, or when only part of a claim is payable. Stating the applicable coverage (for example, hospital confinement, major medical, disability income, accidental death, etc.) supports transparency and aligns with fair claims settlement practices by showing that the insurer is paying according to the policy provisions.

The other options are not required elements of the payment statement. Insurers are not required to list all claimants, disclose reinsurance arrangements (which are typically not visible to policyholders), or include the agent's name and address as part of the claim payment explanation. The essential requirement tested here is identifying the coverage supporting the payment.

NEW QUESTION # 42

When a provider does NOT have an agreement with the insurer for payment, they will be reimbursed

- A. a relative fee.
- B. an absolute fee.
- C. a non-scheduled plan customary fee.
- D. a usual, customary, and reasonable fee.

Answer: D

Explanation:

When a medical provider does not have a contract or payment agreement with an insurer (often called a nonparticipating or out-of-network provider), the insurer generally does not pay based on a negotiated contract rate. Instead, reimbursement is commonly determined using a UCR methodology- Usual, Customary, and Reasonable charges. "Usual" refers to the typical charge a provider makes for a service;

"customary" reflects what providers in the same geographic area commonly charge for that service; and

"reasonable" considers whether the charge is appropriate given the circumstances and local market norms.

Under many major medical plans, the insurer pays a percentage of the UCR amount (subject to deductibles and coinsurance), and

the patient may be responsible for any difference between the provider's billed charge and the insurer's allowed UCR amount (often referred to as balance billing, where permitted).

The other choices do not match standard insurer payment terminology: "absolute" and "relative" fee are not the typical reimbursement basis described for noncontracted providers, and "non-scheduled plan customary fee" is not the recognized standard method used in these plan provisions.

NEW QUESTION # 43

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




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