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Insurance Licensing Pennsylvania Life, Accident and Health Exam Sample Questions (Q53-Q58):

NEW QUESTION # 53

(EXCEPT for fraud, what is the time limit after issue for an insurer to deny an individual health insurance claim based on material misrepresentation in the application for the insurance?)

- A. 1 year
- B. 180 days
- C. 5 years
- **D. 3 years**

Answer: D

Explanation:

Pennsylvania individual health insurance policies include an incontestability provision. Except in cases of fraud, insurers may deny claims based on material misrepresentation only within the first three years after the policy is issued. After this period, statements made in the application become incontestable, even if they were inaccurate. This rule protects insureds by providing long-term policy certainty and aligns with Pennsylvania statutory insurance standards. Fraud remains the sole exception, allowing denial at any time. The other options do not reflect the legally mandated incontestability timeframe.

NEW QUESTION # 54

Which term describes an insurer operating in the state in which it is incorporated?

- A. resident
- B. foreign
- C. participating
- **D. domestic**

Answer: D

Explanation:

In Pennsylvania insurance terminology, an insurer operating in the same state in which it is incorporated is classified as a domestic insurer. Pennsylvania Life, Accident, and Health Insurance study materials clearly define insurer classifications based on the location of incorporation and authorization to do business. A domestic insurer is formed under the laws of Pennsylvania and conducts business within Pennsylvania.

A foreign insurer is incorporated in another state but authorized to operate in Pennsylvania. An alien insurer (not listed as an option) would be incorporated outside the United States. The terms "participating" and "resident" do not describe an insurer's legal status or place of incorporation. Participating refers to a policy that may pay dividends, while resident is a term used for individuals, not insurance companies.

Understanding insurer classifications is essential for licensing exams and regulatory compliance in Pennsylvania. Since the insurer operates in its state of incorporation, the correct and verified answer is domestic.

NEW QUESTION # 55

According to Pennsylvania insurance laws, what action can the insurance company take if the insured unintentionally understated his or her age on the original application?

- A. Current claims must be paid under the incorrect age, but future claims can be paid under the correct age.
- **B. All amounts payable can be reduced to what they would be if the insured had reported the correct age.**

- C. No punitive actions can be taken because the error was unintentional.
- D. The policy can be terminated for misrepresentation.

Answer: B

Explanation:

Under Pennsylvania Life Insurance law, policies are required to contain a misstatement of age provision. This provision addresses situations in which the insured unintentionally understates or overstates their age at the time of application. Pennsylvania-approved insurance study materials clearly state that age is a critical underwriting factor because it directly affects premium calculations and policy benefits.

When an incorrect age is discovered, the insurer cannot cancel the policy or deny claims solely due to the mistake, provided the misstatement was unintentional. Instead, the policy benefits are adjusted to reflect what the premium would have purchased at the correct age. This means that all amounts payable under the policy- including death benefits-are recalculated proportionately based on the accurate age of the insured.

Option A is incorrect because unintentional age misstatements do not constitute material misrepresentation.

Option B is incorrect because Pennsylvania law does not differentiate between current and future claims in this situation. Option D is incorrect because corrective action is allowed, even when the error was accidental.

Therefore, according to Pennsylvania Life Insurance regulations, the insurer may reduce benefits to the amount that the paid premium would have purchased at the correct age, making option C the correct answer.

NEW QUESTION # 56

Which type of insurer is sometimes referred to as a non-participating company?

- **A. Stock Insurer.**
- B. Fraternal Insurer.
- C. Mutual Insurer.
- D. Reciprocal Insurer.

Answer: A

Explanation:

Comprehensive and Detailed 150 to 250 words Explanation with all Pennsylvania Life, Accident, and Health Insurance documents without any external URL or links: = In Pennsylvania insurance education and licensing materials, a stock insurer is sometimes referred to as a non-participating company because policyowners do not share in the insurer's profits. Stock insurers are owned by shareholders, not policyholders, and their primary objective is to generate profit for those shareholders. Any profits earned are distributed as dividends to stockholders rather than to insured individuals.

Non-participating policies issued by stock insurers do not pay policy dividends to policyowners. The premiums charged are fixed, and benefits are contractually guaranteed, but there is no right to share in surplus earnings. This structure contrasts directly with mutual insurers, which are participating companies owned by policyholders who may receive dividends when the company performs well.

Reciprocal insurers are unincorporated associations where members insure one another, while fraternal insurers operate under a lodge system and provide insurance only to members. These entities are not classified as non-participating companies in Pennsylvania licensing terminology. Therefore, under Pennsylvania Life, Accident, and Health Insurance principles, the correct answer is Stock Insurer, making option B the verified choice.

NEW QUESTION # 57

The group health insurance coordination of benefits provision is designed to provide

- A. supplemental accident and dismemberment benefits.
- B. a managed care program to control ongoing illnesses and diseases.
- **C. as much insurance as possible while eliminating over-insurance.**
- D. supplemental dental and vision benefits.

Answer: C

Explanation:

The coordination of benefits (COB) provision in group health insurance policies is designed to prevent duplication of benefits while still allowing the insured to receive full coverage for eligible expenses.

Pennsylvania Life and Health Insurance materials explain that when an individual is covered by more than one group health plan, the

COB provision determines which plan pays first (primary) and which pays second (secondary).

The objective is to ensure that total benefits paid do not exceed the actual cost of medical services. This prevents over-insurance, which could otherwise result in insured individuals receiving more in benefits than the amount of their medical expenses.

Coordination of benefits does not manage care, provide supplemental accident benefits, or offer dental or vision coverage. Instead, it aligns multiple policies to maximize coverage efficiency without violating insurance principles. Pennsylvania-approved study guides emphasize COB as a consumer protection mechanism that controls costs while ensuring appropriate benefit payment.

Therefore, the accurate and verified answer is option A.

NEW QUESTION # 58

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