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Guidewire ClaimCenter Business Analyst - Mammoth Proctored Exam Sample Questions (Q18-Q23):

NEW QUESTION # 18

A claim for an auto accident in California has been assigned to an insurance Adjuster in the Midwest region for investigation and processing. The claim has been flagged as "Low Complexity" in ClaimCenter. The Adjuster has an authority limit for total reserves of \$30,000 and has created reserves totaling \$35,000.

What is the correct approval routing for this transaction?

- A. This transaction will not require approval because the claim is identified as low complexity.
- B. This transaction will require approval because the Adjuster does not work in the same region where the claim was reported.
- C. The transaction will require approval from another team member who has the authority limit to approve.
- **D. The transaction will require approval from the Supervisor of the group.**

Answer: D

Explanation:

Based on the Guidewire ClaimCenter Financials and Authority Limits documentation, the correct behavior for this scenario is determined by the strict enforcement of Authority Limits, regardless of claim complexity or geographic region.

In ClaimCenter, every user is assigned specific authority limits for various financial transactions, including reserves, payments, and recovery reserves. These limits are absolute constraints designed to control financial exposure. In the scenario provided, the Adjuster attempted to set a reserve of \$35,000, which exceeds their authorized limit of \$30,000.

When a user submits a financial transaction that exceeds their pre-configured authority limit, ClaimCenter automatically triggers an Approval Workflow. The system validates the transaction amount against the user's limit at the time of submission. Since the limit is breached, the transaction is not committed immediately to the database as "Submitted"; instead, it enters a "Pending Approval" status.

Routing Logic:

The standard, out-of-the-box approval routing logic in ClaimCenter follows the Group Hierarchy.

- * The system identifies the group to which the Adjuster belongs.
- * It creates an Approval Activity.
- * This activity is assigned to the Supervisor of that group.

The Supervisor must then review the transaction. If the Supervisor has sufficient authority (greater than \$35,000), they can approve it. If the Supervisor also lacks sufficient authority, they must still "approve" it to escalate the request further up the hierarchy to their manager, until it reaches a user with sufficient limits.

Why other options are incorrect:

- * A (Complexity): Claim complexity flags (e.g., "Low Complexity") are often used for Assignment rules (Segment-based assignment) or straight-through processing of documents, but they do not override Financial Authority controls. A low-complexity claim still requires financial oversight if the dollar amount is high.
- * B (Peer Approval): Approval routing is hierarchical, not peer-to-peer. It does not look for "any" team member; it looks specifically for the defined Supervisor.
- * C (Region): The region mismatch might trigger an assignment rule or a validation warning depending on configuration, but the specific trigger for the approval here is purely the financial discrepancy (\$35k > \$30k), not the geography.

NEW QUESTION # 19

Succeed Insurance has a requirement to add a new high-risk indicator to the Claim Status screen for property claims that have a lien on the property. A new icon will be added to the configuration to provide a visual indicator making it easier for Adjusters and other ClaimCenter users to determine that a claim has a lien.

Which two common areas of the user interface (UI) can display the new lien icon? (Choose two.)

- **A. Screen Area**
- B. Workspace
- C. Tab Bar
- **D. Info Bar**
- E. Sidebar

Answer: A,D

Explanation:

In the standard Guidewire ClaimCenter User Interface architecture, high-priority alerts and claim indicators are displayed in two primary locations to ensure visibility:

- * The Info Bar (Option D): This is the persistent strip located at the top of the claim file (just below the Tab Bar). It remains visible regardless of which specific claim sub-screen (Medical, Financials, Notes) the user is navigating. It is designed specifically to host "High Risk Indicators" such as Litigation, Fatalities, Coverage issues, and in this scenario, a "Lien" indicator. This ensures the adjuster is aware of the critical status immediately upon opening the claim.
- * The Screen Area (Option A): Specifically, the Claim Status (or Summary) screen—which resides in the main Screen Area—contains a dedicated section for "Claim Indicators." Here, the icon is displayed along with a text description and potential toggle status (On/Off). The prompt explicitly mentions the requirement to "add a new high-risk indicator to the Claim Status screen," confirming the Screen Area as the second location.

Why other options are incorrect:

- * Sidebar (B): The sidebar (left panel) is used for the "Actions" menu and navigation links (steps) to move between screens. It does not typically host status icons for the claim object itself.
- * Workspace (C): While "Workspace" can refer to the application frame, in UI terminology, it often refers to the specific worksheets (bottom pane) or the container, not the specific UI element for indicators.
- * Tab Bar (E): The Tab Bar is for high-level navigation (Claim, Desktop, Administration, Search) and does not display claim-specific data icons.

NEW QUESTION # 20

Succeed Insurance is implementing a slightly modified version of ClaimCenter to suit its organization's needs. The modification will include adding two new required fields to the standard user interface to capture the reporter's Preferred Language and Preferred Contact Time. This requirement is critical for Succeed to improve efficiency and the expediency of claims processing in its region.

Under which ClaimCenter theme will the User Story Card be found for documenting these requirements?

- A. Intake
- B. Settle/Close
- C. Adjudicate
- D. Special Services

Answer: A

Explanation:

In the Guidewire implementation methodology, User Stories are categorized into Themes that align with the high-level business processes of the claim lifecycle.

* Intake (Option A): The Intake theme covers the First Notice of Loss (FNOL) process and the "New Claim Wizard." The requirement specified is to capture data regarding the "Reporter" (the person reporting the loss) and their contact preferences. In ClaimCenter, Reporter information is collected at the very beginning of the New Claim Wizard (Step 1: Search/Create Policy and Reporter). Because this data entry occurs during the initial setup of the claim, the User Story governing these UI changes belongs to the Intake theme.

* Context: Improving "expediency of claims processing" often relies on accurate data capture at the Intake stage so that downstream assignment and communication can be handled correctly from the start.

Why other options are incorrect:

* Adjudicate (B): This theme covers the investigation, evaluation, and negotiation phases that occur after the claim is created.

* Settle/Close (D): This theme covers the payment issuance and final closure of the file.

* Special Services (C): This typically refers to Vendor Management or specialized sub-processes, not the core FNOL reporter data.

NEW QUESTION # 21

During claim intake and adjudication, Adjusters capture contact information for the insured and all claimants.

To improve customer service and reduce the time required to reach these contacts to gather additional claim information, Succeed Insurance will capture the preferred contact method for all person contacts. The new field will be added to the contact details screen of the user interface (UI) as a drop-down list displaying all valid contact methods including email, mail, and phone.

Which version correctly lists the preferred contact methods in the Typelists tab of the Parties Involved User Story Card?

- A. Option B
- B. Option C
- C. Option D
- D. Option A

Answer: A

Explanation:

To correctly document a Typelist in a User Story Card, the Business Analyst must understand both the data structure (Codes vs. Names) and the configuration state (New vs. Modified).

* Code Validity: In Guidewire, a Typecode (the value stored in the database) must be a unique identifier for each option in the list.

* Option B correctly lists distinct codes: email, mail, and phone.

* Options A and C are incorrect because they list the Typelist Name (PreferredContactMethod) as the Code for every single row.

You cannot have multiple entries with the same primary key (Code) in one list.

* Configuration State (New vs. Modified): The PreferredContactMethod typelist is a standard Base Product feature in Guidewire ClaimCenter. It already exists out-of-the-box.

* Option B correctly identifies the Status as "Modified". When you add values to or configure an existing base typelist, you document it as "Modified".

* Option D is incorrect because it lists the Status as "New". This would imply creating a brand new custom typelist (e.g., MyCustomList_Ext), which is not necessary for standard contact methods.

Therefore, Option B is the only version that has valid, unique codes and the correct configuration status.

NEW QUESTION # 22

An Adjuster at Succeed Insurance increases the reserve on a claim's exposure from \$1,000 to \$1,500 to account for inflation in repair costs. A week later, a Supervisor reviews the claim and wants to know specifically who made this change, the exact date and time it was made, and what the previous value was.

The Supervisor needs a chronological audit trail of changes to the claim file without navigating through complex financial ledgers. Which screen in the ClaimCenter user interface should the Supervisor access to find this information?

- A. Loss Details > Status
- **B. History**
- C. Financials > Transactions
- D. Notes

Answer: B

Explanation:

In Guidewire ClaimCenter, the History screen serves as the automated audit trail for the claim file. It is designed to capture and display a chronological list of significant events and user actions that have occurred throughout the claim's lifecycle.

* Audit Trail Functionality: The History screen automatically records specific types of events, including:

* Field Changes: When critical fields (like Reserve Amounts) are modified, the system logs the "Old Value" and the "New Value."

* Assignment Changes: Tracks when the claim was transferred from one user to another.

* Rule Execution: Logs when specific business rules (like "Exception Flagged") are triggered.

* Data Points: For each entry, the History screen displays the User who performed the action, the Timestamp of the event, and a Description of the change.

Why other options are incorrect:

* Financials > Transactions (A): While this screen shows the financial T-account entries (debits/credits) for the reserve increase, its primary purpose is accounting analysis. It is less efficient for a supervisor looking for a simple "Who/When/What" audit trail compared to the History screen.

* Notes (C): Notes are typically used for qualitative narratives and manual entry. While a system note can be generated for a reserve change, the History screen is the dedicated, non-editable system of record for tracking field changes.

* Loss Details > Status (D): This screen shows the current state of the claim (e.g., Open, Closed, Litigation Status) but does not provide a historical log of previous values or the specific user actions that led to the current state.

NEW QUESTION # 23

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