

# Virginia Insurance Virginia-Life-Annuities-and-Health-Insurance New Exam Materials: Virginia Life, Annuities, and Health Insurance Examination Series 11-01 - TestsDumps Help you Prepare Efficiently

## life insurance exam with correct Answers

An individual applied for an insurance policy and paid the initial premium. The insurer issued a conditional receipt. Five days later the applicant submitted a medical exam. If the policy was issued, what would be the policy's effective date?

- A. The date of policy delivery
- B. The date of the issue
- C. The date of application
- D. The date of the medical exam - ANS D. The date of the medical exam

The Federal Fair Credit Reporting Act

- A. Regulates consumer reports
- B. Protects customer privacy
- C. Regulates telemarketing
- D. Prevents money laundering - ANS A. Regulates consumer reports

Which of the following is NOT the consideration in a policy?

- A. The premium amount paid at the time of application
- B. The promise to pay covered losses
- C. The application given to a prospective insured
- D. Something of value exchanged between parties - ANS C. The application given to a prospective insured

Something of value exchanged between the insurer and the insured is considered an

- A. Acceptance
- B. Legal capacity
- C. Consideration
- D. Offer - ANS C. Consideration

The full premium was submitted with the application for life insurance, and the policy was issued two weeks later as requested. When does the policy coverage become effective?

- A. As of the application date
- B. As of the policy delivery date
- C. As of the first of the month after the policy issue
- D. As of the policy issue date - ANS A. As of the application date

An agent and an applicant for a life insurance policy fill out and sign the application. However, the applicant does not wish to give the agent the initial premium, and no conditional receipt is issued. When will coverage begin?

- A. On the designated effective date
- B. On the application date

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### Virginia Insurance Virginia Life, Annuities, and Health Insurance Examination Series 11-01 Sample Questions (Q140-Q145):

#### NEW QUESTION # 140

Responsibilities of the life insurance agent in the process of underwriting include all of the following EXCEPT:

- A. Seeking any additional information requested by the insurer
- **B. Determining the final rate classification**
- C. Gathering complete information for the application
- D. Notifying the insurer of any material information not in the application

**Answer: B**

Explanation:

Detailed Answer in Step-by-Step Solution:

\* Agents assist underwriting by collecting application data (A), obtaining additional info (C), and reporting material facts (D), but determining the final rate classification (B) is the insurer's underwriter's role, not the agent's.

\* Rate classification involves risk assessment, which is beyond an agent's authority.

The Virginia study guide specifies that agents facilitate underwriting by providing accurate information, while the insurer's underwriters set rates based on that data. Reference: Virginia Life, Annuities, and Health Insurance study guide, section on "Underwriting Process."

#### NEW QUESTION # 141

A coordination of benefits provision is included in group health insurance to reduce:

- **A. Overinsurance**
- B. Probationary periods
- C. Waiting periods
- D. Dependent coverage

**Answer: A**

Explanation:

Detailed Answer in Step-by-Step Solution:

\* The coordination of benefits (COB) provision prevents overinsurance (B) by ensuring that total payments from multiple group plans don't exceed 100% of covered expenses, avoiding duplication.

\* It doesn't affect dependent coverage (A), probationary periods (C), or waiting periods (D), which are unrelated to claim payments.

The Virginia study guide describes COB as a mechanism to coordinate payments among multiple insurers, reducing overinsurance and ensuring fair claim distribution. Reference: Virginia Life, Annuities, and Health Insurance study guide, section on "Group Health Insurance Provisions."

#### NEW QUESTION # 142

A health insurer must generally pay for all of the following types of claims EXCEPT:

- **A. Those incurred after termination of coverage**
- B. Those incurred before termination of coverage
- C. Those related to mental or nervous disorders
- D. Those less than \$20 above the deductible amount

**Answer: A**

Explanation:

Detailed Answer in Step-by-Step Solution:

\* Health insurance covers claims incurred during the policy period (A), not after termination (B), unless extended benefits (e.g., COBRA) apply, which is not indicated here.

\* Claims above the deductible (C), regardless of amount, are payable if covered.

\* Mental or nervous disorder claims (D) are typically covered unless excluded by the policy, which is not specified.

\* Thus, claims after termination (B) are the exception.

The Virginia study guide states that health insurance liability ends upon policy termination, barring specific continuation provisions, making post-termination claims generally non-payable. Reference: Virginia Life, Annuities, and Health Insurance study guide, section on "Health Insurance Coverage Terms."

#### NEW QUESTION # 143

All changes and corrections made to an application for health insurance by an agent must be initialed by the:

- A. Insurance company underwriter
- **B. Applicant**
- C. Agent
- D. Applicant's physician

**Answer: B**

Explanation:

Virginia Code § 38.2-3501 governs health insurance applications, requiring accuracy and applicant consent.

Changes or corrections by an agent (e.g., fixing a misspelled name) must be initialed by the applicant (option B) to verify agreement, as the application becomes part of the contract (Virginia Code § 38.2-3503). Option A (agent) initialing alone risks unauthorized alterations. Option C (physician) is irrelevant; medical input isn't standard for application edits. Option D (underwriter) assesses, not corrects, applications post-submission.

The study guide likely stresses this consumer protection rule, with examples-e.g., an agent correcting a birthdate, initialed by the applicant-ensuring transparency, making B the correct party.

#### NEW QUESTION # 144

All of the following are common features found in health maintenance organizations (HMOs) EXCEPT:

- A. Twenty-four hour access to emergency care
- **B. Discounts on local health spa memberships**
- C. Wellness programs
- D. Outpatient medical services

**Answer: B**

Explanation:

Virginia Code § 38.2-4306 mandates HMO benefits, focusing on comprehensive care. Option A (wellness programs) is common, promoting prevention (e.g., smoking cessation). Option C (24-hour emergency care) is required, ensuring access via PCP coordination or direct ER services. Option D (outpatient services) is standard, covering clinic visits. Option B (discounts on local health spa memberships) isn't a typical HMO feature; while some plans offer wellness incentives, spa discounts are ancillary, not a core benefit under Virginia law or NAIC HMO models. The study guide likely lists HMO staples (A, C, D) with examples-e.g., annual checkups (D)-contrasting them with optional perks like B, making it the exception.

#### NEW QUESTION # 145

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