



**Insurance Test Practice**

# Alaska Insurance Practice Test

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**1. Industrial life insurance (also known as debit insurance) is characterized by:**

- A) Investment-linked cash value growth
- B) Large face amounts and annual premium payments
- C) Group coverage provided through an employer
- ✓ D) Small face amounts with premiums collected weekly or monthly at the insured's home by an agent

*Explanation: Industrial (debit) life insurance features small face amounts (often \$1,000 to \$10,000), with premiums collected on a weekly or monthly basis at the policyholder's home by a debit agent. It was historically designed for low-income individuals who could not afford standard policies.*

**2. A 'conditional' insurance contract requires:**

- ✓ A) The insured to meet certain conditions before the insurer is obligated to perform
- B) Both parties to contribute equally to the premium
- C) The insurer to pay regardless of whether conditions are met
- D) Government approval before coverage begins

*Explanation: An insurance contract is conditional because certain conditions must be met by the policyowner (e.g., paying premiums, filing a timely claim, cooperating with the insurer) for the insurer's promise to pay to be triggered. Failure to meet policy conditions can result in denial of a claim.*

**3. The risk management technique of taking action to reduce the frequency or severity of a potential loss is known as:**

- A) Avoidance
- ✓ B) Reduction
- C) Transfer
- D) Retention

*Explanation: Risk reduction involves implementing measures to minimize the chance or impact of a loss. Examples include installing a sprinkler system to reduce fire damage or wearing a seatbelt to reduce injury in an accident.*

**4. A 'market value adjustment' (MVA) feature in a fixed annuity means:**

- A) The annuity converts to a variable product if market rates exceed the contract rate
- ✓ B) Surrendering the annuity before the end of the guarantee period triggers a positive or negative adjustment based on changes in interest rates since contract issue
- C) The insurer adjusts the annuity's death benefit based on market performance
- D) The annuity's credited rate changes with market interest rates monthly

*Explanation: A market value adjustment (MVA) is a feature in some fixed annuities (typically multi-year guarantee annuities) that adjusts the surrender value up or down based on interest rate changes since the contract was issued. If interest rates have risen since issue, the MVA is negative (reducing the surrender value). If rates have fallen, the MVA is positive. MVAs allow insurers to offer higher guaranteed rates by sharing interest rate risk with the annuity owner.*

**5. A 'health reimbursement arrangement' (HRA) is characterized by:**

- A) A health insurance policy that reimburses providers directly
- B) An employee-funded account that reimburses medical expenses
- C) A retirement account that can only be used for healthcare costs after age 65
- ✓ D) An employer-funded account used to reimburse employees for qualifying medical expenses and premiums tax-free

*Explanation: An HRA is a tax-advantaged arrangement funded ENTIRELY by the employer (no employee contributions). Employers reimburse employees for qualifying medical expenses and health insurance premiums on a tax-free basis. Unused HRA funds may roll over (at the employer's discretion). HRAs are employer-controlled and not portable.*

**6. Under the ACA, health insurers are prohibited from doing all of the following EXCEPT:**

- ✓ A) Charging higher premiums to older adults than young adults up to a 3:1 ratio
- B) Setting annual or lifetime dollar limits on essential health benefits
- C) Charging different premiums based on the insured's health status
- D) Denying coverage based on pre-existing conditions (for non-grandfathered plans)

*Explanation: The ACA prohibits insurers from denying coverage or charging more based on health status (for non-grandfathered plans) and from imposing annual/lifetime dollar limits on EHBs. However, age rating IS permitted — insurers can charge older adults up to 3 times more than younger adults. This is an exception to the ACA's non-discrimination rules.*

**7. What document does an individual member of a group life insurance plan receive as proof of coverage?**

- A) A master policy
- ✓ B) A certificate of insurance
- C) A declaration page
- D) A binder of coverage

*Explanation: Individual group members do not receive the actual policy. Instead, they receive a certificate of insurance that summarizes their coverage, benefits, and conversion rights.*

**8. A licensed producer submits an application for insurance to an authorized insurer with which the producer does not yet hold an active appointment. Under Alaska law, what must happen for the transaction to be valid?**

- A) The transaction is void and illegal
- ✓ B) The insurer must file a notice of appointment with the Division within 30 days of receiving the application
- C) The producer must surrender their license
- D) The client must sign a waiver releasing the insurer

*Explanation: Under AS 21.27.100, an insurer may accept business from a licensed producer and must file an appointment with the Director within 30 days of receiving the application.*

**9. Long-term care insurance benefit triggers typically include:**

- A) Any hospitalization lasting more than 5 days
- B) Loss of income due to disability or injury
- C) Any diagnosis of a chronic illness by a physician
- ✓ D) Inability to perform at least 2 of 6 Activities of Daily Living (ADLs) or severe cognitive impairment

*Explanation: LTC insurance benefits are triggered when the insured cannot perform at least 2 of 6 Activities of Daily Living (ADLs): bathing, dressing, eating, continence, toileting, and transferring. Severe cognitive impairment (such as Alzheimer's) is also a trigger. Both triggers must be certified by a licensed healthcare practitioner.*

**10. The party who receives the income payments from an annuity is called the:**

- A) Beneficiary
- B) Owner
- C) Contingent annuitant
- ✓ D) Annuitant

*Explanation: The annuitant is the person whose life expectancy determines the income payments and the duration of payments. The annuitant receives the income payments. The owner of the annuity contract may or may not be the same person as the annuitant.*

**11. Under Alaska regulations (3 AAC 26.050), within how many working days after receiving notification of a claim must an insurer complete its claim investigation, unless it cannot be completed with due diligence?**

- A) Within 10 working days
- B) Within 15 working days
- ✓ C) Within 30 working days
- D) Within 60 working days

*Explanation: Under 3 AAC 26.050, an insurer must complete its investigation within 30 working days after receiving notification of a claim, unless the investigation cannot reasonably be completed using due diligence.*

**12. Mary has an individual disability income policy with a 30-day elimination period and a \$2,000 monthly benefit. She is totally disabled and unable to work for 45 days. How much benefit will she receive?**

- A) \$2,000
- ✓ B) \$1,000
- C) \$3,000
- D) \$0

*Explanation: The elimination period is a waiting period during which no benefits are paid. Mary is paid only for the days she remains disabled after the 30-day waiting period (45 days total - 30 days = 15 days of payable benefits). Since 15 days is half a month, she receives half of the monthly benefit ( $0.5 * \$2,000 = \$1,000$ ).*

**13. An insurer denies an application for individual disability insurance solely because the applicant has a genetic predisposition for sickle-cell trait or cystic fibrosis, without clinical diagnosis. Under Alaska law, what violation is this?**

- ✓ A) Unfair discrimination based on genetic testing
- B) Sound underwriting practice
- C) Redlining
- D) Twisting

*Explanation: Under AS 21.36.090 and genetic privacy statutes, denying coverage or charging differential rates solely on genetic characteristics without manifest symptoms is prohibited unfair discrimination.*

**14. A 'contributory' group health plan means:**

- A) Employees contribute through payroll taxes
- B) The employer pays 100% of the premium
- C) The government contributes to the premium
- ✓ D) Both the employer and employees contribute to the premium

*Explanation: In a contributory group plan, both the employer and employees share the premium cost. Employees' contributions are typically deducted from their paycheck. Most group health plans in the U.S. are contributory. Contributory plans typically require at least 75% employee participation to prevent adverse selection.*

**15. An insurance producer pays a client's policy application fee out of their own commission account without disclosing it in the contract. What violation is this?**

- ✓ A) Rebating
- B) Twisting
- C) Churning
- D) Sliding

*Explanation: Paying policy fees or providing financial inducements not stated in the contract is illegal rebating under AS 21.36.100.*

**16. Which of the following would disqualify an individual from contributing to a Health Savings Account (HSA)?**

- A) Having dental and vision coverage
- B) Being self-employed
- C) Having a High Deductible Health Plan
- ✓ D) Being enrolled in a general-purpose health FSA or non-HDHP coverage

*Explanation: An individual who is covered by a general-purpose health FSA or any non-HDHP health plan that provides first-dollar coverage is not eligible to contribute to an HSA. However, limited-purpose FSAs for dental and vision do not affect HSA eligibility.*

**17. Which of the following describes the role of a surplus lines broker?**

- A) Placing coverage with admitted insurers at preferred rates
- ✓ B) Placing coverage with non-admitted insurers when admitted coverage is unavailable
- C) Managing an insurer's investment portfolio
- D) Representing the insured exclusively as a fiduciary

*Explanation: Surplus lines brokers are licensed to place coverage with non-admitted (unlicensed in the state) insurers when the risk cannot be placed with admitted companies. The broker must diligently search the admitted market first. Surplus lines policies are not protected by state guaranty funds.*

**18. What is PACE (Program of All-Inclusive Care for the Elderly)?**

- A) A prescription drug assistance program.
- B) A type of Medigap policy.
- ✓ C) A comprehensive healthcare program for frail, elderly individuals who are eligible for nursing home care but wish to remain in the community.
- D) A federal housing program for seniors.

*Explanation: PACE is a Medicare and Medicaid program that provides a full range of preventive, primary, acute, and long-term care services to frail seniors. The goal is to enable them to live at home instead of in a nursing facility.*

**19. A producer in Juneau places an advertisement stating that policyholders of Denali Life are 100% protected against loss because the company is a member of the Alaska Life and Health Insurance Guaranty Association. What is the legal status of this advertisement?**

- A) It is required in all print advertising
- ✓ B) It is an illegal unfair trade practice to use the Guaranty Association as a sales or marketing inducement
- C) It is permitted if approved by the Governor
- D) It is allowed only for life insurance policies with face values under \$100,000

*Explanation: Under AS 21.79.160, it is an unfair trade practice to use the existence of the Alaska Life and Health Insurance Guaranty Association in the sales, solicitation, or advertising of insurance.*

**20. A Risk Retention Group (RRG) is:**

- ✓ A) A liability insurance company owned by its members to insure similar risks
- B) A reinsurance pool for admitted insurers
- C) A self-funded health plan for large employers
- D) A state-created fund that retains premium until claims are paid

*Explanation: A Risk Retention Group (RRG) is a liability insurance company formed under the federal Liability Risk Retention Act, owned by its member-insureds, and formed to insure risks shared by members of a similar industry or trade group.*

**21. The Health Insurance Portability and Accountability Act (HIPAA) provides portability for group health plans. This means it:**

- A) Makes all group health plans portable across state lines.
- B) Allows employees to take their health plan with them when they change jobs.
- C) Requires employers to offer a portable savings account.
- ✓ D) Limits the ability of a new group plan to exclude coverage for pre-existing conditions.

*Explanation: A key feature of HIPAA was to improve the portability of health insurance. It limited the extent to which a new group health plan could impose pre-existing condition exclusions on a new employee who had creditable coverage from a previous plan. This role is now largely handled by the ACA.*

**22. What is a Flexible Spending Account (FSA)?**

- A) A savings account for retirement medical expenses.
- ✓ B) An employer-sponsored account that allows employees to set aside pre-tax dollars for medical expenses.
- C) A portable health savings account owned by the employee.
- D) An account funded solely by the employer.

*Explanation: An FSA is an employer-established benefit. Employees contribute pre-tax dollars through payroll deductions. A key feature is the 'use-it-or-lose-it' rule, where most unused funds at the end of the plan year are forfeited.*

**23. Under the ACA's guaranteed issue provision for individual health insurance an insurer:**

- ✓ A) Must accept all applicants regardless of health status during Open Enrollment
- B) May impose a waiting period based on health history
- C) May charge higher premiums based on pre-existing conditions
- D) May deny coverage based on health status during Open Enrollment

*Explanation: The ACA's guaranteed issue provision requires health insurers in the individual and small group markets to accept all applicants regardless of health status, pre-existing conditions, gender, or other factors during the Open Enrollment Period or a qualifying Special Enrollment Period.*

**24. A disability that is presumed to be total and permanent, such as the loss of sight in both eyes or the loss of two limbs, is called a:**

- A) Recurrent disability
- B) Residual disability
- C) Partial disability
- ✓ D) Presumptive disability

*Explanation: Under a presumptive disability provision, the insured is automatically considered totally disabled, and benefits are paid, even if they can still work. It waives the usual requirements for proving disability for certain severe conditions like total blindness, deafness, or loss of limb.*

**25. The mandatory 'Time Limit on Certain Defenses' provision (similar to the incontestability clause in life insurance) states that after a policy has been in force for how many years the insurer cannot void it for misstatements in the application?**

- A) 1 year
- ✓ B) 2 years
- C) 3 years
- D) 5 years

*Explanation: After an individual A&H policy has been in force for 2 years (under the standard NAIC model provision), the insurer cannot use misstatements in the application to void the policy or deny a claim, except for fraudulent misstatements. This is analogous to the 2-year incontestability clause in life insurance.*

**26. Coinsurance in health insurance means:**

- A) The insured pays a fixed dollar amount per service
- B) The insurer pays 100% of all expenses after a certain date
- C) Two insurers share coverage on the same risk
- ✓ D) After the deductible, the insured pays a percentage of covered expenses while the insurer pays the remainder

*Explanation: Coinsurance requires the insured to pay a percentage of covered expenses after the deductible is satisfied. A common arrangement is 80/20 (the insurer pays 80%, the insured pays 20%) until the out-of-pocket maximum is reached, after which the insurer pays 100%.*

**27. A Managing General Agent (MGA) differs from a regular agent primarily because the MGA:**

- A) Can only sell surplus lines insurance
- B) Represents the insured rather than the insurer
- C) Is not required to hold a state license
- ✓ D) Has broader underwriting and claims authority delegated by the insurer

*Explanation: A Managing General Agent is granted broad authority by an insurer, which may include underwriting, binding coverage, appointing other agents, and settling claims. This authority goes well beyond that of a typical appointed agent.*

**28. A licensed insurance producer changes their legal residential or business address in Juneau. Within how many days must the producer notify the Alaska Division of Insurance in writing?**

- A) Within 10 days
- B) Within 15 days
- ✓ C) Within 30 days
- D) Within 60 days

*Explanation: Under AS 21.27.025 and AS 21.27.380, licensees must notify the Alaska Division of Insurance of any change of address, legal name, or email within 30 days.*

**29. The 'out-of-pocket maximum' in a health insurance plan means:**

- ✓ A) The total annual amount the insured must pay in deductibles, copays, and coinsurance before the insurer pays 100%
- B) The maximum premium the insured can pay annually
- C) The most the insurer will pay for any single claim
- D) The maximum benefit the insurer will pay in one year

*Explanation: The out-of-pocket maximum (or stop-loss) caps the total annual cost-sharing (deductibles + copays + coinsurance) an insured must pay. Once reached, the insurer covers 100% of covered expenses for the rest of the plan year. This protects insureds from catastrophic out-of-pocket expenses.*

**30. A beneficiary in a Medicare Advantage HMO plan generally must receive their care from:**

- A) Any doctor who accepts Medicare.
- ✓ B) Providers within the plan's network, except in an emergency.
- C) Specialists only.
- D) Hospitals only.

*Explanation: Like a traditional HMO, a Medicare Advantage HMO plan requires members to use doctors, hospitals, and other providers that are part of the plan's network. Care from out-of-network providers is typically not covered unless it is an emergency.*

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**31. In a group plan, experience rating is based on:**

- ✓ A) The claims history of the specific group.
- B) The age and gender of the company's CEO.
- C) The overall claims history of the insurance company.
- D) The demographics of the geographic area.

*Explanation: Experience rating is used for large groups. The insurer analyzes the group's own past claims experience to determine the premium for the upcoming year. A group with low claims will generally receive a lower premium than a group with high claims.*

**32. Which nonforfeiture option uses the policy's cash value to purchase a term insurance policy for the same face amount as the original policy?**

- A) Cash Surrender
- ✓ B) Extended Term Insurance
- C) Paid-Up Additions
- D) Reduced Paid-Up Insurance

*Explanation: The Extended Term nonforfeiture option uses the cash value as a single premium to purchase a term life policy with the same face amount as the original policy. The term of the new policy will be for as long a period as the cash value can purchase.*

**33. An insurance policy is considered a unilateral contract because:**

- A) The contract is created by only one party.
- B) Both parties make legally enforceable promises.
- C) The contract's terms are not negotiable.
- ✓ D) Only one party, the insurer, makes a legally enforceable promise.

*Explanation: In a unilateral contract, only the insurer makes a promise that can be legally enforced (the promise to pay a claim). The insured is not legally obligated to pay premiums, although they must do so to keep the contract in force.*

**34. Coordination of Benefits (COB) in group health insurance prevents:**

- A) Employers from self-funding their group health plan
- ✓ B) An insured from collecting benefits exceeding 100% of their actual covered medical expenses
- C) Dependents from being covered under a parent's plan
- D) Employees from having more than one insurer

*Explanation: COB rules prevent double recovery — an insured with two group health plans cannot collect more than their actual covered medical expenses combined. COB rules determine which plan is primary (pays first) and which is secondary (pays after the primary, covering remaining eligible expenses up to 100% of cost).*

**35. A collateral assignment of a life insurance policy is used when the policyowner:**

- A) Transfers the policy to a trust for estate planning
- B) Wants to permanently give the policy to another person
- ✓ C) Pledges the policy as security for a loan while retaining ownership
- D) Assigns the policy to a charity as a tax-deductible gift

*Explanation: A collateral assignment is a temporary, partial transfer of policy rights to a lender as security for a debt. The policyowner retains all ownership rights except those assigned to the lender. When the loan is repaid, the assignment is released. If the insured dies, the lender is paid the outstanding loan balance from the death benefit, and the remainder goes to the named beneficiary.*

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**36. A claimant requests necessary claim forms and instructions from an insurer following a hospital stay. Within how many working days of receiving the request must the insurer provide the forms?**

- ✓ A) Within 10 working days
- B) Within 15 working days
- C) Within 30 working days
- D) Within 45 working days

*Explanation: Under 3 AAC 26.040, an insurer must provide claim forms, instructions, and reasonable assistance within 10 working days of receiving a request.*

**37. The difference between UL Option A (Level Death Benefit) and Option B (Increasing Death Benefit) is:**

- A) Both A and B are correct
- B) Option A is cheaper than Option B for the same initial face amount
- C) Option A has a level cash value; Option B has increasing cash value
- ✓ D) Under Option B the death benefit equals the face amount PLUS the cash value; under Option A it equals only the face amount

*Explanation: Under UL Option A (Level Death Benefit), total death benefit = face amount (net amount at risk + cash value = face amount). Under Option B (Increasing Death Benefit), total death benefit = specified amount PLUS the accumulated cash value. Option B provides a higher total death benefit but costs more because the net amount at risk remains level.*

**38. When applying for an initial resident insurance producer license in Alaska, what background verification requirement must the applicant complete?**

- ✓ A) Submission of fingerprints for state (APSIN) and federal (FBI) criminal history background checks
- B) A credit score check of at least 750
- C) A physical fitness examination
- D) A letter of recommendation from the Alaska Governor

*Explanation: Under AS 21.27.020, initial resident license applicants in Alaska must submit fingerprints for criminal history background checks processed through the Department of Public Safety (APSIN) and the FBI.*

**39. Before a variable life insurance or variable annuity product can be sold, the prospective buyer must receive a:**

- A) Policy summary
- B) Certificate of insurance
- C) Buyer's guide
- ✓ D) Prospectus

*Explanation: Because variable products are classified as securities, federal law requires that a prospectus be provided to the prospective buyer before or at the time of solicitation. The prospectus contains detailed information about the product's investment objectives, risks, fees, and expenses.*

**40. A disability buy-sell agreement funded by a disability policy is designed to:**

- ✓ A) Provide funds for the able partners to buy out the business interest of a disabled partner.
- B) Provide income to a disabled partner.
- C) Pay for a disabled partner's medical bills.
- D) Cover the overhead expenses of the business.

*Explanation: Similar to a life insurance-funded buy-sell, a disability buy-out policy provides the funds needed for the business or remaining partners to execute the buy-sell agreement and purchase the disabled partner's share of the business.*

**41. A Multiple Employer Trust (MET) allows:**

- A) Employers to self-fund their health benefits.
- ✓ B) Multiple small employers to pool together to purchase group health insurance as if they were a single large employer.
- C) One large employer to offer multiple health plans.
- D) Employees to choose from multiple insurance companies.

*Explanation: A MET is a legal entity that allows multiple small employers in the same industry to join forces to obtain group health benefits. This gives them access to the lower rates and more favorable underwriting that are typically available only to large groups.*

**42. The percentage of covered medical expenses that the insured is required to pay after the deductible has been met is known as:**

- A) The premium
- B) The out-of-pocket maximum
- ✓ C) Coinsurance
- D) The copayment

*Explanation: Coinsurance is a cost-sharing arrangement where the insured pays a percentage of the bill (e.g., 20%), and the insurer pays the remaining percentage (e.g., 80%).*

**43. All variable product sales must be suitable for the customer. Suitability is determined by evaluating all of the following EXCEPT:**

- A) The customer's financial situation and needs
- ✓ B) The customer's political affiliations
- C) The customer's tax status
- D) The customer's investment objectives and risk tolerance

*Explanation: FINRA suitability rules require that any recommendation of a variable product be based on a thorough evaluation of the customer's financial situation, investment objectives, risk tolerance, tax status, time horizon, liquidity needs, and existing holdings. Personal characteristics like political affiliation are irrelevant to suitability.*

**44. A 'creditable coverage' letter is important because it:**

- ✓ A) Proves an individual had prior health coverage, which was used to reduce pre-existing condition exclusion periods before the ACA.
- B) Guarantees eligibility for Medicare.
- C) Reduces the premium for a new health plan.
- D) Acts as a certificate of insurance.

*Explanation: Before the ACA prohibited pre-existing condition exclusions, a certificate of creditable coverage was crucial. It proved that a person had continuous health coverage, which allowed them to reduce or eliminate any pre-existing condition waiting periods when they moved to a new group health plan.*

**45. The 'notice of claims' provision in a health insurance policy requires:**

- ✓ A) The insured to give written notice of a claim to the insurer within a specified time after a covered loss
- B) All health claims to be submitted electronically to qualify for reimbursement
- C) Both the insured and the provider to submit separate claim notices
- D) The insurer to notify the insured within 30 days of any claim decision

*Explanation: The notice of claims provision requires the insured to notify the insurer of a claim within a specified time period (typically within 20 days of the loss or as soon as reasonably possible). Timely notice allows the insurer to investigate the claim and provide claim forms. Failure to provide timely notice does not necessarily void coverage but may complicate the claims process.*

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**46. In a direct writing or direct response system, insurance is sold:**

- A) Only through exclusive agents
- ✓ B) Directly by the insurer to the consumer without the use of agents
- C) Only through surplus lines brokers
- D) Only through independent agents

*Explanation: In a direct writing (or direct response) system, the insurer markets and sells policies directly to the public through its own employees, mail, telephone, or the internet. There are no independent or exclusive agents involved in the transaction.*

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**47. The rider that provides an additional death benefit if the insured dies as a result of an accident is the:**

- A) Cost of Living Rider
- B) Waiver of Premium Rider
- C) Guaranteed Insurability Rider
- ✓ D) Accidental Death Benefit (ADB) Rider

*Explanation: The Accidental Death Benefit (ADB) rider, sometimes called 'double indemnity,' pays an additional amount, often equal to the face amount of the policy, if the insured's death is the result of an accident and occurs within a specified time (e.g., 90 days) of that accident.*

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**48. Which type of policy pays a fixed, per-day benefit for each day the insured is hospitalized, regardless of the actual costs?**

- A) Surgical Expense Insurance
- B) Major Medical Insurance
- ✓ C) Hospital Indemnity Insurance
- D) Comprehensive Health Insurance

*Explanation: Hospital Indemnity (or Hospital Confinement) insurance pays a specified daily, weekly, or monthly cash benefit directly to the insured during a hospital stay. This money can be used for any purpose, not just medical bills.*

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**49. What legal principle prevents a party from re-asserting a right they have previously waived?**

- A) Subrogation
- B) Adhesion
- C) Waiver
- ✓ D) Estoppel

*Explanation: Estoppel is the legal principle that prevents someone from arguing something or asserting a right that contradicts what they previously said or did. For example, if an insurer consistently accepts late premiums, they may be estopped from canceling the policy for a late payment.*

**50. The provision that addresses a disability that reappears after the insured has returned to work is the:**

- A) Presumptive Disability Provision
- ✓ B) Recurrent Disability Provision
- C) Waiver of Premium Provision
- D) Elimination Period Provision

*Explanation: The recurrent disability provision states that if the insured suffers a relapse of the same disability within a certain period (e.g., 6 months) after returning to work, it will be treated as a continuation of the prior disability. This means the insured does not have to satisfy a new elimination period.*