



Insurance Test Practice

Delaware Insurance Practice Test

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1. The 'notice of conversion rights' under group life insurance must be provided to:

- ✓ A) Employees whose group life coverage terminates for any qualifying reason, notifying them of their right to convert to individual coverage
- B) Only employees who are voluntarily resigning
- C) Only employees who are terminated involuntarily
- D) Employees who have been with the company for more than 5 years

Explanation: When an employee's group life coverage terminates (for any qualifying reason — termination, retirement, reduced hours), the employer or insurer must notify the employee of their conversion rights. The employee has 31 days to exercise the conversion right. Failure to provide notice may extend the time for conversion.

2. The 'policy date' on a life insurance policy affects:

- A) Only the date premiums become due
- ✓ B) The policy anniversary date, premium due dates, and the start of the incontestability and suicide clause periods
- C) The date the beneficiary designation becomes effective
- D) Only the effective date of coverage

Explanation: The policy date (or issue date) establishes the starting point for several important time-sensitive provisions including: premium due dates, policy anniversary dates, the 2-year incontestability period, and the 1-2 year suicide exclusion period. Understanding the policy date is important for answering exam questions about contestability and suicide clause timing.

3. How are premiums for an individual life insurance policy generally treated for tax purposes?

- ✓ A) They are not tax-deductible.
- B) They are tax-credits.
- C) They are tax-deductible.
- D) They are partially tax-deductible.

Explanation: Premiums paid for individual life insurance policies are considered a personal expense and are therefore not tax-deductible.

4. Under health insurance, an 'in-network' provider is one that:

- A) Is located within a specified geographic radius of the insured's home
- B) Is a specialist who provides only inpatient care
- ✓ C) Has contracted with the health plan to provide services at negotiated rates
- D) Provides only emergency care services

Explanation: An in-network provider has signed a contract with the health insurance plan agreeing to accept negotiated rates for covered services. Using in-network providers results in lower cost-sharing for the insured. Out-of-network providers have not signed such contracts and may charge higher amounts, resulting in higher cost-sharing for the insured.

5. Which of the following is considered a qualified medical expense for HSA withdrawals?

- A) Cosmetic surgery for aesthetic purposes
- B) Health insurance premiums paid outside of COBRA or Medicare
- ✓ C) Prescription medications
- D) Gym membership fees

Explanation: Prescription medications are qualified medical expenses under IRS Section 213(d). Cosmetic surgery for purely aesthetic reasons, gym memberships, and most health insurance premiums (with exceptions like COBRA and Medicare) are not qualified expenses.

6. The Law of Large Numbers helps an insurer to:

- A) Eliminate risk entirely
- ✓ B) Predict the approximate number of losses that will occur in a group
- C) Guarantee that no losses will occur
- D) Predict the specific individuals who will suffer a loss

Explanation: The Law of Large Numbers states that as the size of the sample population increases, the actual loss experience will more closely approximate the true underlying probability. It allows insurers to predict losses for a group, not individuals.

7. An insurance contract is conditional, which means:

- ✓ A) The insurer's obligation to pay a claim depends on the insured performing certain duties.
- B) The value exchanged is unequal.
- C) Only one party makes an enforceable promise.
- D) The contract terms are non-negotiable.

Explanation: A conditional contract requires that certain conditions must be met before performance is required. For an insurer to pay a claim, the insured must satisfy conditions like paying premiums and providing proof of loss.

8. Under Delaware law, what is the effect of an insurer engaging in unfair claim settlement practices with such frequency as to indicate a general business practice?

- A) It automatically makes all insurer contracts void
- B) It requires federal intervention by OSHA
- C) It transfers the claims to the Delaware Attorney General
- ✓ D) It triggers administrative sanctions, fines, and potential license suspension

Explanation: A pattern of unfair claim practices indicating a general business practice subjects the insurer to administrative penalties, fines, and certificate revocation.

9. The ACA's minimum value standard requires employer-sponsored coverage to:

- A) Cover at least 50% of the total allowed cost of benefits under the plan
- ✓ B) Cover at least 60% of the total allowed cost of benefits under the plan
- C) Cover 80% of costs for all essential health benefits
- D) Provide coverage with no deductible

Explanation: Under the ACA, employer-sponsored coverage must provide 'minimum value' (MV) — covering at least 60% of the total allowed cost of benefits under the plan on average (equivalent to a Bronze-level plan). Plans that don't meet MV may result in employees being eligible for marketplace subsidies, triggering potential employer penalties.

10. What is the main difference between an HMO and a PPO?

- ✓ A) HMOs require a gatekeeper and have a limited network; PPOs offer more flexibility and out-of-network options.
- B) PPOs cover preventative care; HMOs do not.
- C) HMOs use a capitation fee; PPOs use a fee-for-service model.
- D) PPOs are federally regulated; HMOs are state-regulated.

Explanation: The primary distinction lies in the network and choice. HMOs are more restrictive, requiring members to use a limited network and a PCP gatekeeper. PPOs offer a broader network and the freedom to see out-of-network providers, albeit at a higher cost.

11. Can a Delaware insurance producer give a customer a promotional calendar, pen, or coffee mug bearing the agency's logo without violating the anti-rebating statute?

- A) No, any item of value is an illegal rebate
- B) Yes, but only if the customer signs an anti-rebate waiver
- C) Yes, provided the item costs more than \$100
- ✓ D) Yes, provided the item has nominal value (typically \$25-\$50 or less) and is for advertising

Explanation: Nominal promotional merchandise (pens, calendars) bearing the producer/insurer logo are considered standard advertising items, not unlawful rebates.

12. What is a 'Taft-Hartley Trust'?

- A) A type of MET for non-profit organizations.
- ✓ B) A trust established by a labor union and employers to provide health and welfare benefits to union members.
- C) A trust used for estate planning.
- D) A trust for funding executive retirement plans.

Explanation: Taft-Hartley trusts, or multi-employer plans, are formed through collective bargaining agreements between a labor union and multiple employers. They are managed by a board of trustees with equal representation from labor and management.

13. Medicare Part B primarily provides coverage for:

- A) Prescription drugs
- B) Dental and vision
- C) Inpatient hospital care
- ✓ D) Physician services and outpatient care

Explanation: Medicare Part B is 'medical insurance.' It helps cover medically necessary doctors' services, outpatient hospital care, durable medical equipment, and many other medical services and supplies that are not covered by Part A.

14. Qualified annuities held within a Traditional IRA are subject to Required Minimum Distributions (RMDs). Under current law, RMDs must generally begin by April 1 following the year the owner turns:

- A) Age 75
- ✓ B) Age 73
- C) Age 59 1/2
- D) Age 65

Explanation: Under the SECURE 2.0 Act, the required beginning date for RMDs from qualified retirement accounts (including qualified annuities in IRAs) is age 73 for individuals born between 1951 and 1959, increasing to age 75 for those born in 1960 or later. Failure to take the RMD results in a penalty tax on the amount not distributed.

15. If an HSA account holder under the age of 65 withdraws funds for a non-qualified, non-medical expense, what is the tax consequence?

- A) The withdrawal is tax-free
- ✓ B) The withdrawal is subject to income tax plus a 20% penalty
- C) The withdrawal is subject to income tax only
- D) The withdrawal is subject to a 10% penalty only

Explanation: HSA withdrawals used for non-qualified medical expenses before age 65 are subject to regular income tax plus a 20% penalty. After age 65, the penalty is waived, but income tax still applies to non-qualified withdrawals.

16. A producer offers to refund 25% of the first-year commission to an applicant as an incentive to purchase a life insurance policy. What unfair practice is this?

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

Explanation: Under 18 Del. C. § 2304(14), rebating is giving, offering, or allowing any valuable consideration or premium rebate not stated in the insurance policy.

17. The 'life with period certain' annuity payout option guarantees:

- A) A refund of the principal if the annuitant dies.
- ✓ B) Payments for the annuitant's life, and for a specified minimum period if the annuitant dies early.
- C) Payments for a fixed period only.
- D) Payments for the lives of two annuitants.

Explanation: This option provides a lifetime income to the annuitant. If the annuitant dies before the end of the specified 'certain period' (e.g., 10 or 20 years), payments will continue to a beneficiary for the remainder of that period.

18. Which of the following best describes the role of a Managing General Agent (MGA)?

- A) A government official who oversees insurance markets
- ✓ B) An agent with broad authority from the insurer, including underwriting, binding, and claims functions
- C) An agent who manages a producer's agency on their behalf
- D) An agent who exclusively manages claims for the insurer

Explanation: A Managing General Agent (MGA) is an agent with expanded authority granted by the insurer, including the power to underwrite risks, bind coverage, issue policies, and sometimes handle claims and appointing sub-agents, all on behalf of the insurer.

19. A policyowner who stops paying premiums on a whole life policy and chooses the Cash Surrender option will receive:

- A) A paid-up term policy.
- B) The total premiums paid back.
- ✓ C) The accumulated cash value, less any outstanding loans.
- D) A reduced paid-up whole life policy.

Explanation: The Cash Surrender Value nonforfeiture option allows the policyowner to terminate the policy and receive the net cash value (cash value minus any surrender charges and outstanding loans).

20. The length of time that disability income benefits will be paid is called the:

- ✓ A) Benefit period
- B) Coverage period
- C) Payment period
- D) Elimination period

Explanation: The benefit period is the maximum amount of time that benefits will be paid for a single disability. It can range from a few months (for short-term disability) to several years or even to age 65 (for long-term disability).

21. 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.

22. A fixed dollar amount that an insured pays for a specific covered service, such as a doctor's visit, is a(n):

- ✓ A) Copayment
- B) Premium
- C) Deductible
- D) Coinsurance

Explanation: A copayment (or copay) is a set fee paid by the insured at the time of service. For example, a plan might require a \$30 copay for each office visit.

23. The 'recurrent disability' provision in a disability income policy:

- A) Allows the insured to receive partial benefits during recovery
- B) Provides an additional benefit for each recurrence of a disability
- C) Requires a new elimination period for each new episode of disability
- ✓ D) Treats a disability that recurs within a specified period as a continuation of the original disability, not a new claim

Explanation: The recurrent disability provision protects the insured from losing benefits when a disability recurs. If the same or related disability returns within a specified period (often 6 months) after the insured returned to work, it is treated as a continuation of the original claim — not a new claim requiring a new elimination period.

24. A producer repeatedly uses the cash surrender value of an insured's existing life policy to purchase new policies within the same insurer solely to generate commissions. What is this practice called?

- A) Rebating
- B) Defamation
- C) Coercion
- ✓ D) Churning

Explanation: Churning involves inducing a policyholder to replace or borrow against existing coverage to buy new policies within the same insurer primarily for commissions.

25. Susan has a life insurance policy with an Accidental Death Benefit (Double Indemnity) rider for \$100,000. Her base policy face amount is \$100,000. If Susan dies from a heart attack, how much will her beneficiary receive?

- A) \$200,000
- ✓ B) \$100,000
- C) \$0
- D) \$50,000

Explanation: The Accidental Death Benefit rider only pays the additional benefit if death results from an accident. Because a heart attack is an illness (natural cause), only the base policy face amount of \$100,000 is paid.

26. Which dividend option allows the policyowner to purchase additional small units of whole life insurance?

- A) Cash Payout
- ✓ B) Paid-Up Additions
- C) Accumulate at Interest
- D) Reduction of Premium

Explanation: The Paid-Up Additions dividend option uses the annual dividend to purchase single premium, additional blocks of whole life insurance. These additions increase both the death benefit and the cash value of the policy.

27. What is the difference between Universal Life Option A and Option B?

- A) Option A is term insurance, while Option B is permanent insurance.
- B) Option A has a flexible premium, while Option B has a fixed premium.
- ✓ C) Option A provides a level death benefit, while Option B provides an increasing death benefit.
- D) Option A's cash value is invested in the general account, while Option B's is in separate accounts.

Explanation: Under Universal Life, Option A (or Option 1) provides a level death benefit where the cash value is included within the face amount. Option B (or Option 2) provides an increasing death benefit, which is the face amount plus the accumulated cash value.

28. Which of the following risk classifications would result in the lowest premium?

- ✓ A) Preferred
- B) Declined
- C) Standard
- D) Substandard

Explanation: A preferred risk classification is for individuals who meet certain criteria that qualify them for a lower-than-average risk of loss (e.g., non-smoker, healthy lifestyle). They receive the most favorable premium rates.

29. An individual health insurance policy that the insurer cannot cancel and cannot increase the premium on is classified as:

- A) Optionally renewable
- ✓ B) Non-cancellable
- C) Conditionally renewable
- D) Guaranteed renewable

Explanation: A non-cancellable policy provides the strongest protection for the insured. The insurer cannot cancel the policy, raise the premium, or reduce benefits, as long as premiums are paid on time. This is the most expensive type of renewability provision.

30. Who is responsible for paying the expenses incurred during an examination of an insurer conducted by the Delaware Department of Insurance?

- A) The Delaware State General Fund
- B) The National Association of Insurance Commissioners (NAIC)
- C) An annual fee charged to all licensed resident producers
- ✓ D) The examined insurer

Explanation: Under 18 Del. C. § 322, the insurer examined must pay the proper charges incurred in the examination upon presentation of a detailed account.

31. A 'market value adjustment' (MVA) provision in a fixed annuity:

- ✓ A) Applies a positive or negative adjustment to the surrender value based on changes in interest rates since the contract was issued
- B) Guarantees the annuity owner receives at least market-rate returns
- C) Adjusts the insurer's reserve requirements based on market conditions
- D) Automatically resets the credited rate to match current market rates

Explanation: An MVA provision adjusts the surrender value of a fixed annuity based on changes in interest rates since the contract was issued. If rates have risen since purchase, an early surrender may result in a downward adjustment (penalty). If rates have fallen, the adjustment may be positive. MVAs reflect the insurer's ability to reinvest at different rates.

32. In a group life insurance plan, who holds the master contract?

- ✓ A) The employer or group policyholder
- B) Each individual employee
- C) The insurance commissioner
- D) The beneficiaries of the insured members

Explanation: In group life insurance, the master contract is issued to and held by the employer or entity sponsoring the plan. Individual members receive certificates of insurance as evidence of coverage.

33. Scheduled premium variable life insurance differs from variable universal life in that:

- A) Scheduled premium VL does not require FINRA registration
- B) VUL cannot have a guaranteed minimum death benefit
- C) Scheduled premium VL has variable death benefit minimums; VUL does not
- ✓ D) Scheduled premium VL has fixed premiums; VUL has flexible premiums

Explanation: Scheduled (Fixed) Premium Variable Life Insurance has fixed, level premiums similar to whole life — the premium amount is set at issue and does not vary. Variable Universal Life (VUL) combines variable investing with the premium flexibility of UL — the policyowner can vary premium amounts within limits. Both require FINRA registration to sell.

34. Which of the following best describes the 'payout phase' (annuity phase) of a deferred annuity?

- A) The period during which surrender charges apply
- B) The phase during which the insurer earns interest on invested premiums
- ✓ C) The phase during which the accumulated value is converted into regular income payments
- D) The period during which premium payments accumulate value

Explanation: The payout phase (distribution phase or annuity phase) begins when the accumulated value in a deferred annuity is converted (annuitized) into regular income payments. The policyowner selects a payout option (life only, period certain, joint and survivor, etc.) and regular payments begin based on that option and the amount available.

35. How often must the Delaware Insurance Commissioner examine domestic insurers admitted in Delaware?

- A) At least once every year
- B) At least once every 3 years
- ✓ C) At least once every 5 years
- D) Only upon written policyholder complaint

Explanation: Under 18 Del. C. § 318, the Commissioner must examine each domestic insurer at least once every 5 years, or more frequently if deemed prudent.

36. In an insurance contract, the insured's consideration is the:

- A) Issuance of the policy
- B) Promise to pay claims
- ✓ C) Application and initial premium payment
- D) Agent's commission

Explanation: Consideration is the value exchanged by the parties to a contract. The insured's consideration consists of the statements made in the application and the payment of the first premium.

37. A universal life policy's 'planned periodic premium' is best described as:

- A) The premium that guarantees the death benefit will remain level throughout the policy
- B) The premium set by the state insurance commissioner
- ✓ C) The premium amount the policyowner intends to pay — but UL allows flexibility to pay more or less (within limits)
- D) The minimum premium required by law to keep the policy in force

Explanation: In a universal life policy, the planned periodic premium is the premium amount the policyowner designs to pay, but UL's flexible premium feature allows the policyowner to pay more or less. As long as the policy's cash value covers monthly deductions, the policy remains in force even if no premium is paid. Paying less than planned can risk lapse if the cash value is depleted.

38. What is the purpose of stop-loss insurance for a self-funded employer?

- A) To provide health insurance to employees.
- B) To insure against employee lawsuits.
- C) To cover administrative costs.
- ✓ D) To limit the employer's liability for large or catastrophic claims.

Explanation: An employer with a self-funded plan will purchase stop-loss insurance from a commercial insurer. This policy protects the employer from unexpectedly high claims by reimbursing the employer for claims that exceed a certain dollar amount (either on an individual or aggregate basis).

39. Human Life Value (HLV) is a method used to:

- A) Determine the cash value of a whole life policy
- B) Assess the maximum loan amount available against a life policy
- C) Calculate the mortality rate used by actuaries
- ✓ D) Estimate the present value of an individual's future earnings for insurance needs analysis

Explanation: The Human Life Value (HLV) approach estimates the economic value of a person's remaining earning potential (net of taxes and personal living expenses), discounted to the present value. This amount represents the financial loss the insured's dependents would suffer upon the insured's premature death. It is used to help determine appropriate life insurance coverage amounts.

40. If an insurer allows an unlicensed individual to solicit insurance applications using the company's letterhead, business cards, and office space, the insurer may be liable under the doctrine of:

- ✓ A) Apparent authority
- B) Implied authority
- C) Express authority
- D) Subrogation

Explanation: Apparent authority is created when an insurer's actions lead the public to reasonably believe that a person is authorized to act on the insurer's behalf. Providing company materials and office space to an individual creates the appearance of an agency relationship, even if no formal authority was granted.

41. 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.

42. John has a Whole Life policy with a Waiver of Premium rider. He is totally disabled in a car accident and remains disabled for 8 months before recovering. What happens to the premiums paid during his disability?

- A) Under no condition are any premiums refunded
- ✓ B) The premiums are waived during his disability, and any premiums paid during the initial 6-month waiting period are refunded
- C) The insurer pays the premiums but deducts them from the cash value
- D) The rider only applies if he remains disabled for life

Explanation: The Waiver of Premium rider waives premiums after a specified waiting period (typically 6 months) during total disability. Once met, the waiver is retroactive to the start of the disability, and any premiums paid during the waiting period are refunded.

43. The 'conversion period' for a convertible term policy typically expires:

- ✓ A) Before the end of the term, often by a specific age (e.g., 65) or number of years
- B) When the insured exercises the conversion for the first time
- C) After the incontestability period
- D) At the end of the full policy term

Explanation: The conversion period is the window during which the term policyowner can convert to permanent insurance. It typically has an expiration date — either a specific age (e.g., the insured must be under 65) or a specified number of years into the term. After the conversion period expires, the right to convert without evidence of insurability is lost.

44. Which of the following is the most restrictive beneficiary designation for a life insurance policy?

- A) Contingent beneficiary
- B) Class beneficiary
- ✓ C) Irrevocable beneficiary
- D) Revocable beneficiary

Explanation: An irrevocable beneficiary designation is the most restrictive because it gives the beneficiary vested rights in the policy. The policyowner cannot change the beneficiary, take policy loans, assign the policy, or surrender it without the irrevocable beneficiary's written consent. This is often used as a form of financial security for creditors or ex-spouses in divorce agreements.

45. In addition to or in lieu of suspending or revoking a license, what administrative penalty may the Delaware Insurance Commissioner levy against a producer?

- A) Community service for up to 100 hours
- ✓ B) An administrative fine up to \$1,000 per violation
- C) Seizure of personal residence
- D) Revocation of Delaware driver's license

Explanation: Under 18 Del. C. § 1712(d), the Commissioner may impose a fine of up to \$1,000 per violation in addition to or in lieu of suspension or revocation.

46. Which of the following is an example of a speculative risk?

- A) A work-related injury
- B) A house fire
- C) A car accident
- ✓ D) A gambling debt

Explanation: Speculative risk involves a chance of either loss or gain. Gambling, stock market investments, and starting a new business are all examples of speculative risks, which are typically not insurable.

47. What is a 'grandfathered' health plan under the ACA?

- A) A government-sponsored health plan.
- ✓ B) A plan that existed before the ACA was enacted (March 23,2010) and has not undergone significant changes.
- C) A plan that only covers senior citizens.
- D) A plan that meets all ACA requirements.

Explanation: Grandfathered plans are exempt from many of the ACA's mandates, such as covering preventive care at no cost or adhering to the metal level requirements. However, they can lose this status if they make significant changes that reduce benefits or increase costs for members.

48. What is the role of the Centers for Medicare & Medicaid Services (CMS)?

- ✓ A) It is a federal agency that administers the Medicare and Medicaid programs.
- B) It is a private insurance company.
- C) It is a consumer advocacy group.
- D) It is a state agency that regulates HMOs.

Explanation: CMS is the federal agency within the U.S. Department of Health and Human Services that oversees the Medicare program, and works in partnership with state governments to administer Medicaid, CHIP, and health insurance portability standards.

49. An insured has a health plan with a \$2,000 deductible and 80/20 coinsurance. If the insured has a covered medical bill of \$12,000, how much will the INSURER pay?

- ✓ A) \$8,000.00
- B) \$12,000.00
- C) \$9,600.00
- D) \$10,000.00

Explanation: First, the insured pays the \$2,000 deductible, leaving a balance of \$10,000. Then, the coinsurance applies to this balance. The insurer pays 80% of \$10,000, which is \$8,000. The insured pays the remaining 20% (\$2,000) plus the initial deductible, for a total of \$4,000.

50. Under Delaware insurance regulations, within how many working days must an insurer acknowledge receipt of a notice of claim?

- A) 5 working days
- B) 10 working days
- ✓ C) 15 working days
- D) 30 working days

Explanation: Under Delaware Regulation 902, insurers must acknowledge receipt of a notice of claim within 15 working days.