



Insurance Test Practice

Montana Insurance Practice Test

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1. Under MCA § 33-20-141, what notice requirement applies if an insurer intends to cancel a life insurance policy for nonpayment of premium?

- ✓ A) The insurer must provide at least 30 days written notice of cancellation, which runs concurrently with the statutory grace period
- B) The insurer may cancel instantly at midnight on the due date without notice
- C) The insurer must give 90 days advance written notice by registered courier
- D) Notice is only required if the insured is over age 70

Explanation: MCA § 33-20-141 requires at least 30 days written notice of cancellation for nonpayment of premium, running concurrently with the 30-day grace period.

2. An LTC policy that is 'tax-qualified' means it meets certain federal standards set by:

- A) The Affordable Care Act
- B) The IRS
- ✓ C) HIPAA
- D) The Social Security Administration

Explanation: A tax-qualified LTC policy must meet the standards established by the Health Insurance Portability and Accountability Act (HIPAA). This allows premiums to be potentially tax-deductible and benefits to be received tax-free up to a certain limit.

3. 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.

4. The 'probationary period' in a disability income policy refers to the:

- A) Time an insured must be disabled before benefits are paid.
- ✓ B) Time between when the policy is issued and when sickness coverage goes into effect.
- C) Maximum time benefits will be paid.
- D) Time an employee must wait to be eligible for group coverage.

Explanation: The probationary period is a one-time period that begins on the policy's effective date, typically 15-30 days. It specifies that no benefits will be paid for a sickness that begins during this initial period. This is designed to protect the insurer from adverse selection (people buying a policy because they know they are about to get sick).

5. How long does an insurer's appointment of a producer remain in effect under Montana law, provided the producer maintains an active license?

- A) Appointments must be renewed annually on January 1st
- B) Appointments expire after exactly two years matching the producer's CE cycle
- C) Appointments expire every 6 months unless re-certified by the insurer
- ✓ D) The appointment is perpetual and remains in effect until terminated by the insurer or Commissioner

Explanation: Under Montana law and CSI procedure, producer appointments are continuous and perpetual until formally terminated.

6. 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.

7. Annuities are unique among insurance products in that they are primarily designed to:

- ✓ A) Liquidate accumulated assets into a guaranteed income stream over time
- B) Insure against property losses
- C) Accumulate tax-deferred savings with no distribution requirement
- D) Provide a death benefit to protect survivors

Explanation: The primary unique purpose of an annuity — what sets it apart from other financial and insurance products — is its function as a mechanism for systematically distributing (liquidating) accumulated savings into periodic income payments, particularly providing income that cannot be outlived in a life annuity structure.

8. Under group term life insurance, if an employee converts their coverage to an individual whole life policy upon termination:

- ✓ A) The premium is based on the insured's attained age at the time of conversion with no evidence of insurability required
- B) The converted policy will have the same premium as the group plan for 2 years
- C) The premium is based on the group rate they were paying before termination
- D) The converted policy has a 2-year contestability period beginning from the original group enrollment date

Explanation: Upon conversion of group term to individual whole life, the insured pays the standard premium for their current age (attained age) for the type of individual policy issued. No evidence of insurability is required. The premium will be significantly higher than the group rate because individual policies are more expensive per unit of coverage than group rates.

9. Under the Medical Loss Ratio (MLR) requirement, what percentage of premium revenue must individual and small group health insurers spend on medical claims and quality improvement?

- A) 75%
- B) 70%
- C) 85%
- ✓ D) 80%

Explanation: The ACA requires individual and small group health insurers to spend at least 80% of premium revenue on medical claims and quality improvement activities. This is known as the 80/20 rule. If insurers fail to meet this threshold, they must issue rebates to policyholders.

10. The 'cash value accumulation test' (CVAT) is one method used to determine if a life insurance policy qualifies as:

- A) A variable annuity product
- B) A modified endowment contract
- C) A qualified retirement plan
- ✓ D) A life insurance contract under IRC Section 7702

Explanation: IRC Section 7702 establishes two tests to determine whether a contract qualifies as life insurance for tax purposes: the Cash Value Accumulation Test (CVAT) and the Guideline Premium and Corridor Test (GPT). Under the CVAT, the policy's cash value cannot exceed the net single premium needed to fund the death benefit. Policies must satisfy one of these tests to receive favorable life insurance tax treatment (tax-deferred growth, income-tax-free death benefit).

11. What is the primary purpose of health insurance?

- ✓ A) To protect against the financial consequences of illness or injury
- B) To replace income lost during retirement
- C) To provide investment returns to the policyholder
- D) To fund long-term savings goals

Explanation: The primary purpose of health insurance is to protect individuals and families from the potentially catastrophic financial costs of illness, injury, or disability. It covers medical expenses and, in some products, provides income replacement during periods of disability.

12. What is a primary consideration for an agent when recommending a variable annuity?

- ✓ A) All of the above.
- B) The client's risk tolerance.
- C) The client's understanding of market risk and separate accounts.
- D) The client's age and retirement timeline.

Explanation: When recommending a variable annuity, an agent must consider the client's entire financial picture, including their age, time horizon, financial goals, and especially their tolerance for and understanding of investment risk, since the principal is not guaranteed.

13. Under the ACA employer mandate for ALEs with 100+ employees in 2015 and 50+ in 2016 and beyond:

- A) All full-time employees must be enrolled in coverage whether they want it or not
- B) All plans must be grandfathered to be exempt from the mandate
- C) Coverage must be free to all employees with no employee contributions allowed
- ✓ D) The employer must offer qualifying coverage to full-time employees (30+ hours/week) and their dependents

Explanation: The ACA employer mandate requires ALEs (50+ FTEs) to offer minimum essential coverage that is affordable and meets minimum value to all full-time employees (those working 30+ hours/week) and their dependents (not spouses). Employers who fail to offer coverage (or offer unaffordable/insufficient coverage) and have at least one FT employee receive a premium tax credit may owe an employer shared responsibility payment.

14. 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.

15. The 'spendthrift clause' in a life insurance policy protects death benefit proceeds by:

- ✓ A) Preventing creditors of the beneficiary from attaching or garnishing proceeds held by the insurer
- B) Requiring court approval before proceeds are paid
- C) Reducing the death benefit if the insured had excessive debt at death
- D) Requiring the beneficiary to spend proceeds within 5 years

Explanation: A spendthrift clause prevents the beneficiary's creditors from garnishing or attaching the death benefit proceeds while they are held by the insurer (prior to payment or when held under a settlement option). This protects the proceeds for their intended purpose — supporting the beneficiary. Once paid to the beneficiary, the funds may lose this protection.

16. A retiree, Helen, wants to invest \$100,000 in an immediate annuity. She wants to receive the absolute maximum monthly income possible for the rest of her life and does not care about leaving any remaining funds to beneficiaries. Which payout option should she choose?

- A) Life with Period Certain
- B) Cash Refund
- ✓ C) Life Only (Straight Life)
- D) Joint and Survivor

Explanation: The Life Only (Straight Life) option provides the highest monthly income because it stops immediately upon the annuitant's death, with no refund or survivor guarantees. The insurer assumes less risk, resulting in a higher payout rate.

17. Health insurance policies that include a 'preexisting condition' exclusion may deny benefits for:

- ✓ A) A medical condition for which treatment was sought within a specified lookback period before coverage began
- B) Conditions that run in the insured's family
- C) Any illness diagnosed after the policy is issued
- D) All chronic conditions indefinitely

Explanation: A preexisting condition exclusion limits coverage for conditions that existed (or for which care was received or recommended) within a specified period before the policy's effective date. Under HIPAA, the lookback period is 6 months before enrollment. The ACA eliminated preexisting condition exclusions for most health insurance plans.

18. Annuity suitability regulations require the producer to make a record of:

- A) The client's family medical history.
- B) The producer's commission rate.
- C) The client's political views.
- ✓ D) The recommendation made to the client and the basis for it.

Explanation: Producers must document their recommendations and the reasons why a particular product was deemed suitable. This record-keeping is a key part of complying with suitability rules and protects both the consumer and the producer.

19. What is the tax implication of an accelerated death benefit paid to a terminally ill insured?

- ✓ A) It is generally received income tax-free.
- B) It is fully taxable as income.
- C) It is subject to a 10% penalty.
- D) It is taxed as a capital gain.

Explanation: Under HIPAA, accelerated death benefits paid to a terminally or chronically ill insured are generally received income tax-free, just like a regular death benefit. This allows individuals to access their benefits without a significant tax burden.

20. An annuity is designed primarily to provide:

- A) A death benefit
- B) Coverage for medical expenses
- ✓ C) Protection against outliving one's income
- D) Short-term savings

Explanation: Annuities are financial contracts issued by life insurance companies that are designed to protect against the risk of 'superannuation' or outliving your money. They provide a stream of income, typically during retirement.

21. If a Montana health insurer fails to furnish official claim forms within 15 days of receiving notice, how does the claimant satisfy the proof of loss requirement?

- A) The claim is automatically deemed approved for maximum policy limits
- B) The claimant must petition the Montana Supreme Court for an emergency writ
- ✓ C) By submitting written proof detailing the occurrence, character, and extent of the loss for which claim is made
- D) The claimant is excused from providing any proof of loss whatsoever

Explanation: Under MCA § 33-22-206, if forms are not furnished within 15 days, the claimant satisfies proof of loss by providing written details of the loss.

22. The cash value in a whole life policy grows on a:

- A) Taxable basis
- ✓ B) Tax-deferred basis
- C) Annual taxable distribution basis
- D) Capital gains tax basis

Explanation: Cash value accumulation inside a whole life policy grows on a tax-deferred basis — meaning no income tax is owed on the growth as long as it remains inside the policy. This tax advantage makes whole life a potentially attractive long-term financial planning tool.

23. In an indexed annuity, the 'spread' (also called 'margin' or 'asset fee') refers to:

- A) The difference between the annuity's value and the surrender value
- B) The difference between the cap rate and the participation rate
- ✓ C) A percentage the insurer subtracts from the index gain before crediting interest to the annuity
- D) The guaranteed minimum interest rate

Explanation: The spread is a percentage that the insurer deducts from the calculated index-linked interest before crediting it to the contract. For example, if the index gains 8% and the spread is 2%, the annuity is credited with 6%. The spread is one of three mechanisms (along with the cap rate and participation rate) that limit how much of the index gain is credited.

24. A copayment in a health insurance plan is:

- ✓ A) A fixed dollar amount the insured pays for a specific service regardless of the total charge
- B) The insured's share of the annual premium
- C) A percentage of covered expenses the insured pays
- D) The amount paid by both the insurer and insured equally

Explanation: A copayment (or copay) is a fixed dollar amount paid by the insured for a specific healthcare service (e.g., \$25 for a doctor visit, \$15 for a generic prescription). The copay is paid at the time of service, and the insurer pays the remainder of the covered charge. Copays typically do not count toward meeting the deductible.

25. Which type of life insurance offers pure death benefit protection with no cash value?

- A) Universal Life
- B) Endowment
- ✓ C) Term Life
- D) Whole Life

Explanation: Term Life insurance provides coverage for a specific period (term). It pays a death benefit only if the insured dies during that term. It is the purest form of life insurance and does not build any cash value.

26. Which type of managed care plan allows members to see any provider within the network without a referral and reimburses providers on a discounted fee-for-service basis?

- A) HMO
- B) EPO
- ✓ C) PPO
- D) POS

Explanation: A Preferred Provider Organization (PPO) uses a discounted fee-for-service model and does not require referrals to see specialists. Members have the freedom to see any in-network provider and may also see out-of-network providers at a higher cost. PPOs operate as open panels.

27. For a contract to be valid, all parties must be of legal age, mentally capable, and not under the influence of drugs or alcohol. This is the requirement of:

- A) Consideration
- B) Offer and Acceptance
- C) Legal Purpose
- ✓ D) Competent Parties

Explanation: Competent Parties is an essential element of a valid contract. It ensures that all parties involved have the legal capacity to enter into an agreement.

28. When must an insurance producer or insurer in Montana report suspected fraudulent insurance transactions to the Commissioner?

- A) Only after an indictment has been issued by a grand jury
- B) Annually in an aggregated report due each December 31st
- ✓ C) Promptly to the CSI Criminal Investigation Bureau upon obtaining a reasonable belief of fraud
- D) Reporting suspected fraud is strictly voluntary and never required under Montana law

Explanation: MCA § 33-1-1205 mandates that insurers and licensees report suspected fraudulent insurance acts to the Commissioner's Criminal Investigation Bureau.

29. The coordination of benefits (COB) provision in a health insurance policy is designed to:

- A) Ensure that one plan pays for all services.
- ✓ B) Prevent overinsurance and duplication of benefits when a person is covered by more than one plan.
- C) Determine which provider an insured must see.
- D) Coordinate care between a PCP and a specialist.

Explanation: The COB provision establishes a process to determine which health plan is the 'primary' payer and which is 'secondary' when a person is covered by two or more plans. This ensures that the total benefits paid do not exceed 100% of the medical expenses.

30. The 'general account' of an insurance company holds:

- A) Premium funds held in trust for future policyholders only
- B) Assets required by the state guaranty association
- ✓ C) The insurance company's assets backing fixed annuity guarantees and other obligations
- D) Only the separate account assets for variable annuities

Explanation: The general account holds the insurer's assets used to back its fixed obligations — including fixed annuity guarantees, whole life cash values, and other general liabilities. Fixed annuity owners are general creditors of the insurer for their policy values. This contrasts with the separate account, which holds variable annuity assets segregated from the general account.

31. Which of the following best describes the payment model used by Health Maintenance Organizations (HMOs)?

- ✓ A) Prepaid or capitation model where providers receive a fixed amount per member per month
- B) Indemnity-based reimbursement after services are rendered
- C) Cost-plus pricing based on actual expenses incurred
- D) Fee-for-service with no discounts

Explanation: In an HMO, providers are typically paid through capitation, meaning they receive a fixed, prepaid amount per enrolled member per month regardless of whether the member uses services. This incentivizes preventive care and cost control.

32. A family policy typically provides what kind of insurance on the children?

- A) Universal life insurance
- B) Whole life insurance
- C) Variable life insurance
- ✓ D) Term life insurance

Explanation: A family policy is a package policy that usually provides whole life coverage for the primary breadwinner and a smaller amount of convertible term life insurance for the spouse and children.

33. Why does Montana regulation require strict disclosure when an existing life insurance policy is replaced?

- A) To prevent consumers from ever purchasing more than one life insurance policy
- ✓ B) To protect consumers from losing accrued cash values, incurring new surrender charges, and restarting the 2-year contestability and suicide periods
- C) To guarantee that state premium taxes are doubled on replacement sales
- D) To allow the Montana CSI to set the premium rate for the replacement policy

Explanation: Replacement rules protect consumers because replacing a policy often incurs new surrender charges, restarts the 2-year suicide and contestability periods, and increases costs due to advanced age.

34. Under the Affordable Care Act (ACA), what is the purpose of the 'metal levels' (Bronze, Silver, Gold, Platinum)?

- A) They indicate the quality of care provided by the plan.
- B) They correspond to different income levels for eligibility.
- ✓ C) They classify plans based on their actuarial value, or how costs are shared between the plan and the insured.
- D) They determine the size of the provider network.

Explanation: The metal levels represent the average percentage of health care costs the plan will cover. Bronze plans cover about 60%, Silver 70%, Gold 80%, and Platinum 90%. A plan with a higher metal level will have a higher premium but lower out-of-pocket costs.

35. Which of the following health plans combines features of an HMO and a PPO?

- ✓ A) Point of Service (POS) Plan
- B) High Deductible Health Plan (HDHP)
- C) Exclusive Provider Organization (EPO)
- D) Indemnity Plan

Explanation: A Point of Service (POS) plan is a hybrid model. Like an HMO, it requires members to choose a PCP. However, like a PPO, it allows them to go out-of-network for care, but at a higher cost and with more paperwork.

36. Under MCA § 33-18-202, which of the following is considered illegal 'misrepresentation'?

- A) Quoting premiums based on verified actuarial tables approved by the CSI
- ✓ B) Issuing or circulating illustrations or sales presentations that deceive or mislead regarding policy benefits, terms, or dividends
- C) Explaining the standard exclusion for intentional self-inflicted injuries in disability policies
- D) Providing a complete policy summary alongside an insurance application

Explanation: Misrepresentation includes publishing or circulating misleading, false, or deceptive estimates of policy terms, values, or dividends (MCA § 33-18-202).

37. When a lapsed health insurance policy is reinstated in Montana, what coverage restriction applies to sickness claims under MCA § 33-22-205?

- ✓ A) Accidental injuries are covered immediately, but sickness is covered only if it begins more than 10 days after the reinstatement date
- B) Both accidents and sickness are covered immediately from minute one
- C) Sickness claims are permanently excluded for the life of the policy
- D) Accidents are excluded for 30 days while sickness is covered immediately

Explanation: Under MCA § 33-22-205, reinstated health policies cover accidental injuries immediately, but cover sickness only after a 10-day probationary window to prevent adverse selection.

38. What is the statutory purpose of the Montana Life and Health Insurance Guaranty Association (MCA § 33-10-201)?

- A) To provide state-funded health insurance to low-income agricultural workers
- ✓ B) To protect Montana resident policyholders, beneficiaries, and annuitants against financial loss caused by the insolvency of an admitted insurance company
- C) To establish uniform sales commission rates for Montana life producers
- D) To bail out bankrupt commercial real estate developers in Montana

Explanation: The Guaranty Association exists under MCA § 33-10-201 to protect Montana policyholders and beneficiaries if an admitted life or health insurer becomes insolvent.

39. What is the minimum passing score required on the Pearson VUE Montana insurance producer licensing examination?

- A) 70%
- B) 65%
- ✓ C) 75%
- D) 80%

Explanation: The official passing score for Montana insurance producer examinations administered by Pearson VUE is 75%.

40. A hazard that increases the probability of loss due to a person's dishonest character is called a:

- A) Physical hazard
- B) Morale hazard
- ✓ C) Moral hazard
- D) Speculative hazard

Explanation: A moral hazard is dishonesty or character defects that increase the frequency or severity of loss. It differs from a morale hazard, which is carelessness due to indifference because insurance exists.

41. An employer wants to insure a key executive under the company's group life plan with a benefit amount significantly higher than other employees. Which group insurance principle could this potentially violate?

- A) The doctrine of adhesion
- B) The law of large numbers
- ✓ C) The requirement that benefit amounts be determined by a formula that precludes individual selection
- D) The principle of indemnity

Explanation: A fundamental principle of group underwriting is that benefit amounts must be determined by a formula related to factors such as salary, position, or length of service. This prevents individual selection (adverse selection) by not allowing specific individuals to choose disproportionately high coverage.

42. 'Incidents of ownership' in a life insurance policy include all of the following EXCEPT:

- A) The right to borrow against the policy
- B) The right to assign the policy
- C) The right to change the beneficiary
- ✓ D) The right to receive the death benefit as a named beneficiary

Explanation: Incidents of ownership refer to the economic and legal rights a person holds in a policy, such as the right to change the beneficiary, assign the policy, borrow against it, or surrender it. Simply being the named beneficiary does not constitute an incident of ownership. If the insured retains any incidents of ownership at death, the policy proceeds are included in the taxable estate.

43. A 'per capita' beneficiary designation means that:

- A) The death benefit is distributed by bloodline.
- ✓ B) The death benefit is divided equally among only the surviving named beneficiaries.
- C) The death benefit is passed down to the beneficiaries' heirs.
- D) The death benefit is paid to the insured's estate.

Explanation: 'Per capita' (by the head) means the death benefit is shared equally among the surviving beneficiaries in a designated class. If one beneficiary in the class has died, their share is redistributed among the other survivors in that class, and their heirs receive nothing.

44. David's house is damaged by fire. His insurer pays him \$50,000 to repair the damage. David then attempts to sue the negligent neighbor who caused the fire for the same \$50,000. Which principle prevents David from collecting twice?

- A) The principle of utmost good faith
- ✓ B) The principle of subrogation
- C) The principle of insurable interest
- D) The principle of estoppel

Explanation: Subrogation transfers the insured's right of recovery against a negligent third party to the insurer after a loss is paid. This prevents the insured from collecting twice for the same loss (violating indemnity).

45. A 'binder' in insurance provides:

- A) A legal document binding the insured to the policy for 5 years
- B) Permanent coverage until the formal policy is cancelled
- C) Evidence that the insured has paid all premiums in advance
- ✓ D) Temporary insurance coverage until a formal policy is issued

Explanation: A binder is a temporary insurance agreement that provides immediate coverage while the formal policy is being prepared. It can be oral or written and is legally binding on the insurer. Coverage under a binder typically lasts until the formal policy is issued or the binder expires.

46. How are employer-paid premiums for group life insurance treated for tax purposes for the employee?

- A) The premium for the first \$100,000 of coverage is tax-free to the employee.
- B) They are always taxable income to the employee.
- ✓ C) The premium for the first \$50,000 of coverage is tax-free to the employee.
- D) They are always tax-free to the employee.

Explanation: The value of employer-paid premiums for the first \$50,000 of group term life insurance coverage is not considered taxable income to the employee. The value of the premium for coverage above \$50,000 is considered taxable income, based on an IRS table.

47. Which life insurance product requires a securities license (FINRA Series 6 or 7) in addition to a life insurance license to sell?

- A) Term Life
- ✓ B) Variable Universal Life
- C) Universal Life
- D) Whole Life

Explanation: Any 'variable' life insurance or annuity product involves investments in separate accounts (securities). Therefore, a producer must have both a state life insurance license and a federal securities registration (like Series 6 or 7) to sell them.

48. A 'capitation' payment arrangement in managed care means:

- ✓ A) The provider receives a fixed per-member-per-month payment to provide covered services regardless of utilization
- B) The provider is paid per service rendered
- C) The insurer caps the maximum benefit paid for any service
- D) The patient pays a fixed co-payment for all services

Explanation: Capitation is a payment model where managed care plans pay providers a fixed per-member-per-month (PMPM) amount to provide all covered services to enrolled members, regardless of how much or how little care is actually provided. This creates incentives for providers to manage care efficiently and maintain member health.

49. 'Presumptive disability' in a disability income policy means:

- A) The insurer presumes the insured is disabled without medical evidence
- ✓ B) Certain specified severe conditions (e.g., loss of limbs, sight, or speech) automatically qualify the insured for total disability benefits without a waiting period
- C) The insured is presumed to be disabled based on their job duties
- D) Benefits are paid based on the physician's presumptive diagnosis

Explanation: Presumptive disability provisions automatically waive the elimination period and provide immediate total disability benefits when the insured suffers certain catastrophic losses — such as complete and permanent loss of sight, hearing, speech, or the use of two limbs. The insured is presumed permanently and totally disabled from the specified loss.

50. An insured, Greg, commits suicide 18 months after purchasing a life insurance policy that contains a standard 2-year suicide clause. What action will the insurer take regarding the beneficiary's claim?

- A) Pay the full face amount of the policy
- ✓ B) Deny the claim and refund only the premiums paid
- C) Deny the claim and refund nothing
- D) Pay 50% of the face amount as a compromise

Explanation: Under the suicide clause, if the insured commits suicide within the first two years of the policy, the insurer's liability is limited to a refund of the premiums paid. After two years, the full death benefit must be paid.