Insurance Test Practice

South Carolina Insurance Practice Test

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1. In an Interest-Sensitive Whole Life policy, the cash value can grow at a rate that is:

A) Fixed and guaranteed for the life of the policy.
B) Determined by the policyowner's choice of subaccounts.
C) Tied directly to the stock market.
✔ D) Greater than the guaranteed minimum rate if the insurer's investments perform well.

Explanation: Interest-Sensitive Whole Life (also called Current Assumption Whole Life) offers a guaranteed minimum interest rate on cash value, but may credit a higher, current interest rate based on the performance of the insurer's general account investments.

2. The period of time after a benefit trigger is met but before LTC benefits begin is called the:

A) Probationary period
B) Benefit period
C) Grace period
✔ D) Elimination period

Explanation: Similar to a disability policy, an LTC policy has an elimination period (or waiting period). This is the number of days the insured must be receiving care before the policy will start paying benefits. Common periods are 30, 60, or 90 days.

3. A traditional fee-for-service health plan is also known as a(n):

✔ A) Indemnity Plan
B) Capitation Plan
C) HMO Plan
D) Managed Care Plan

Explanation: An indemnity plan is a traditional plan that pays a set percentage of charges for services, allowing the insured to see any medical provider they choose. The insurer reimburses the insured or pays the provider directly after a claim is filed.

4. Which of the following is a PRIMARY eligibility requirement for opening a Health Savings Account (HSA)?

A) The individual must be over the age of 50
B) The individual must be employed full-time
C) The individual must be enrolled in any health insurance plan
✔ D) The individual must be enrolled in a High Deductible Health Plan (HDHP)

Explanation: To be eligible for an HSA, an individual must be covered under a qualifying High Deductible Health Plan (HDHP) and cannot be enrolled in Medicare or claimed as a dependent on another person's tax return.

5. A 'first-to-die' or joint life policy pays the death benefit when:

A) Both insureds die simultaneously.
B) The policyowner dies.
✔ C) The first insured dies.
D) The second insured dies.

Explanation: A joint life policy insures two or more lives and pays the death benefit when the first of the insureds dies. The policy then terminates. It is less common than survivorship life.

6. 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.

7. The 'elimination period' (waiting period) in health insurance serves to:

A) Delay coverage for all newly issued health insurance policies by 30 days
✓ B) Reduce premiums by having the insured absorb short-term losses before insurance benefits begin
C) Prevent the insured from filing multiple claims in one year
D) Protect the insurer from pre-existing conditions indefinitely

Explanation: An elimination period (waiting period) is the initial period after disability or LTC begins during which no benefits are paid. The insured self-insures for this period. Choosing a longer elimination period lowers premiums significantly. This works best for insureds with sufficient emergency funds to cover the waiting period costs.

8. What is a 'rider' in an annuity contract?

A) The primary beneficiary of the annuity.
✓ B) An optional benefit or feature that can be added to the contract, usually for an additional cost.
C) The person who drives the annuitant to appointments.
D) The application form for the annuity.

Explanation: A rider is an add-on to a base annuity contract that provides supplemental benefits. Common annuity riders include Guaranteed Lifetime Withdrawal Benefits (GLWB) or enhanced death benefits.

9. If an underwriter discovers an applicant has a hazardous hobby, they are most likely to:

A) Decline the application outright.
B) Issue the policy as a preferred risk.
✓ C) Issue the policy with a flat extra premium or an exclusion rider.
D) Require the applicant to cease the hobby.

Explanation: For applicants with hazardous occupations or hobbies (e.g., scuba diving, auto racing), insurers often manage the increased risk by charging a flat extra premium or by adding an exclusion rider that eliminates coverage for death resulting from that specific activity.

10. A 'multi-year guaranteed annuity' (MYGA) is:

✔ A) A fixed annuity that locks in a guaranteed interest rate for a specified multi-year period
B) A variable annuity with a guaranteed minimum income benefit rider
C) An annuity funded by multiple premium payments over many years
D) An annuity that makes guaranteed payments for multiple years after annuitization

Explanation: A MYGA is a type of fixed deferred annuity that guarantees a fixed interest rate for a specified number of years (e.g., 3, 5, or 7 years) — similar to a CD at a bank. At the end of the guaranteed period, the owner can renew at a new rate, surrender, or exchange the contract. MYGAs are transparent and simple fixed annuity products.

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11. An insurer incorporated under the laws of Germany wants to sell disability income policies in Columbia. In South Carolina, how is this insurer classified?

A) Domestic insurer
B) Foreign insurer
✔ C) Alien insurer
D) Non-admitted insurer

Explanation: An alien insurer is one incorporated under the laws of a country outside the United States.

12. How long does an insurer have to make a decision to approve or deny a claim after receiving complete proof of loss?

✔ A) 15 working days
B) 30 working days
C) 45 calendar days
D) 15 calendar days

Explanation: South Carolina claims regulations require insurers to accept or deny a claim within 15 working days after receiving a completed proof of loss.

13. Modified premium whole life insurance is characterized by:

A) A death benefit that decreases over time
B) Premiums that decrease after the first year
✔ C) Lower premiums in the early years that increase after a specified period
D) A policy that becomes paid-up after 10 years automatically

Explanation: Modified premium whole life (or Modified Whole Life) charges lower premiums during an initial period (usually the first 3-5 years) that then increase to a higher level premium for the remainder of the policy. This appeals to buyers who expect their income to increase over time but want permanent coverage now.

14. The 'delayed payment' clause in a life insurance policy allows the insurer to delay paying policy loan proceeds for up to:

- ✔ A) 6 months for cash value loans
- B) 90 days
- C) 1 year
- D) 30 days

Explanation: The Delayed Payment provision allows the insurer to delay the payment of any cash surrender value or policy loan proceeds for up to 6 months. This protects the insurer during periods of extreme financial stress (such as a market crisis) that could threaten its liquidity. This clause does not apply to the payment of death benefits.

15. A policyowner wants to ensure that her spouse receives a monthly income from the life insurance proceeds, but also wants to ensure their children receive the principal after the spouse dies. Which settlement option should be chosen?

- A) Life Income
- B) Fixed Period
- C) Fixed Amount
- ✔ D) Interest Only

Explanation: The 'Interest Only' option is ideal for this scenario. The insurer holds the principal and pays out the interest earned to the spouse. Upon the spouse's death, the principal is then paid to the contingent beneficiaries (the children).

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16. A 'monthly average' indexed crediting method in a fixed-indexed annuity:

- A) Credits interest based only on the month-end index value
- B) Credits interest monthly instead of annually
- ✔ C) Calculates the index return based on the average of the 12 monthly ending index values during the crediting period compared to the beginning value
- D) Averages the cap rate and floor rate to determine the credited interest

Explanation: The monthly average (or monthly averaging) method calculates interest by comparing the average of the 12 month-end index values during the crediting period to the beginning index value. This smooths out extreme peaks and troughs. In volatile markets, monthly averaging may produce lower credits than annual point-to-point if the index rises sharply near year-end.

17. For a non-qualified annuity, the 'cost basis' is:

- A) The current accumulation value of the contract
- B) The total death benefit that will be paid tax-free
- C) The actuarial present value of all future income payments
- ✔ D) The total after-tax premiums paid into the contract (not yet received back as income)

Explanation: The cost basis in a non-qualified annuity equals the total after-tax premiums paid into the contract. Withdrawals are taxed LIFO (gains first). The cost basis represents dollars that were already taxed and can be recovered tax-free. Once all gains are withdrawn, subsequent withdrawals are treated as tax-free return of basis.

18. A major medical policy is designed to cover:

A) Dental and vision expenses.
B) Routine check-ups and preventative care only.
C) Small, predictable medical expenses.
✔ D) Catastrophic medical expenses with high coverage limits, deductibles, and coinsurance.

Explanation: Major medical insurance provides broad coverage and high limits to protect against large, unpredictable medical expenses. It is characterized by deductibles and coinsurance, which require the insured to share in the cost of care.

19. If an underwriter determines an applicant is a higher-than-average risk, the applicant may be classified as:

✔ A) Substandard
B) Standard
C) Preferred
D) Non-insurable

Explanation: A substandard or 'rated' risk is one that carries a higher-than-normal risk of loss. The insurer may issue a policy, but it will be at a higher premium or with a special exclusion.

20. The 'death benefit' provision in most deferred variable annuities:

A) Is not included because variable annuities are pure investment products
B) Only pays the current account value at the time of death
✔ C) Guarantees the beneficiary will receive at least the greater of the account value or the total premiums paid if the owner dies during accumulation
D) Pays twice the original premium if death occurs before age 65

Explanation: Most variable deferred annuities include a death benefit that guarantees the beneficiary receives at least the greater of: (a) the current account value or (b) the total premiums paid (minus prior withdrawals). This 'return of premium' death benefit guarantees heirs won't receive less than was invested, even if the market has declined.

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21. An independent insurance agent represents:

✔ A) Multiple insurers and owns their own book of business
B) The state insurance department in regulatory proceedings
C) Only one insurer exclusively
D) The insured exclusively as a fiduciary

Explanation: An independent agent represents multiple insurance companies and owns the expirations (renewals) on the policies they write. They can place business with any insurer they are appointed with and typically work on a commission basis.

22. The 'net amount at risk' in a life insurance policy is:

A) The insurer's total risk exposure on all policies
B) The total death benefit minus any unpaid loans
C) The premium amount at risk of not being paid
✔ D) The difference between the face amount and the policy's cash value

Explanation: The net amount at risk is the portion of the death benefit that the insurer is actually 'at risk' for — calculated as the face amount minus the accumulated cash value. As cash value grows, the net amount at risk decreases. In term insurance, there is no cash value, so the entire face amount is the net amount at risk.

23. How are distributions (withdrawals or loans) from a Modified Endowment Contract (MEC) taxed?

A) As capital gains.
✔ B) Last-In, First-Out (LIFO) - earnings are taxed first.
C) First-In, First-Out (FIFO) - return of premium first.
D) Tax-free.

Explanation: MECs are subject to less favorable tax rules. All distributions are taxed on a Last-In, First-Out (LIFO) basis, meaning the taxable earnings are withdrawn first. Additionally, a 10% penalty may apply to distributions taken before age 59 1/2.

24. A Point-of-Service (POS) plan combines features of:

A) COBRA and individual coverage
B) Term and whole life insurance adapted for health coverage
✔ C) HMO and PPO — requiring a PCP like an HMO but allowing out-of-network care like a PPO
D) Medicare Part A and Part B

Explanation: A POS (Point-of-Service) plan is a hybrid between an HMO and a PPO. Like an HMO, it requires members to choose a primary care physician and obtain referrals for specialists within the network. Like a PPO, members can go out-of-network but pay higher cost-sharing for doing so.

25. The facility of payment clause, often found in industrial or group life policies, allows the insurer to:

A) Pay the benefit directly to a hospital or nursing home.
✔ B) Pay a portion of the death benefit to a person or entity that has incurred funeral or medical expenses on behalf of the insured.
C) Facilitate an immediate loan from the policy's cash value.
D) Pay the claim to the state if no beneficiary can be found.

Explanation: The facility of payment clause permits the insurer to pay benefits (usually a limited amount) to a person who appears equitably entitled to it, even if they are not the named beneficiary. This is typically done to cover final expenses and avoids delays when the named beneficiary is a minor, deceased, or cannot be located.

26. An Accidental Death and Dismemberment (AD&D) policy pays benefits according to a schedule. A 'capital' loss (such as loss of life or loss of both hands) typically pays what percentage of the principal sum?

A) 50%
✓ B) 100%
C) 75%
D) 25%

Explanation: A capital loss is the most severe type covered under an AD&D policy and pays the full principal sum (100%). Capital losses include loss of life, loss of both hands, loss of both feet, loss of sight in both eyes, or any combination of two. Loss of one hand, one foot, or sight in one eye typically pays 50% (the 'capital' sum).

27. An Exclusive Provider Organization (EPO) differs from a PPO primarily because an EPO:

A) Uses a capitation payment model
B) Requires a primary care physician referral for all services
✓ C) Provides no coverage for out-of-network services except in emergencies
D) Is regulated exclusively by the federal government

Explanation: An EPO restricts coverage to in-network providers only, with the exception of emergency situations. Unlike a PPO, which provides reduced benefits for out-of-network care, an EPO generally provides no coverage for non-emergency services obtained outside the network.

28. A purchasing group under the federal Liability Risk Retention Act:

A) Is the same as a risk retention group
✓ B) Enables a group to purchase liability insurance on behalf of members from admitted or risk retention group insurers
C) Purchases property insurance for municipalities
D) Provides coverage only for professional liability

Explanation: A Purchasing Group is a group formed under the federal Liability Risk Retention Act to purchase liability insurance on behalf of its members from an insurer that is either admitted in a member's state or a risk retention group. Purchasing groups have more regulatory freedom to operate across state lines.

29. A hazard that arises from an individual's carelessness because they feel protected by insurance is called a:

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

Explanation: A morale hazard (also called attitudinal hazard) is carelessness or indifference to potential loss because the person knows they are insured. For example, leaving valuables unsecured because 'insurance will cover it.' This differs from a moral hazard, which involves intentional dishonesty or fraud.

30. What is the Medigap Open Enrollment Period?

A) The 7-month period around the 65th birthday.
B) The period after leaving an employer health plan.
✓ C) The 6-month period beginning the first day of the month in which an individual is both 65 or older and enrolled in Medicare Part B.
D) The period from October 15 to December 7 each year.

Explanation: This is a one-time, 6-month period that is the best time to buy a Medigap policy. During this time, an insurance company cannot use medical underwriting to refuse to sell you any Medigap policy it offers, charge you more, or make you wait for coverage to start.

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31. An agent fails to appear at a scheduled South Carolina Department of Insurance (SCDOI) hearing regarding a client complaint. What action can the Commissioner take?

✓ A) Suspend or revoke the license in the agent's absence.
B) Dismiss the complaint.
C) Sentence the agent to jail immediately.
D) Fine the customer who complained.

Explanation: If a licensee fails to appear at a scheduled hearing, the Commissioner can proceed in their absence and suspend or revoke their license.

32. A fraternal benefit society differs from a stock or mutual insurer because it:

A) Only provides group life insurance to employers
B) Is regulated by the federal government, not state agencies
✓ C) Is nonprofit and sells insurance only to its own members through a lodge system
D) Sells coverage to the general public without any membership requirement

Explanation: A fraternal benefit society is a nonprofit organization with a lodge or ritualistic structure that provides insurance and social benefits only to its members. Membership is usually based on a common bond such as religion, ethnicity, or profession.

33. An insurance company, Palmetto Life, wants to start selling health insurance policies in Columbia. Which entity is responsible for administering and enforcing insurance laws in South Carolina?

A) The Governor of South Carolina
✓ B) The South Carolina Department of Insurance (SCDOI)
C) The National Association of Insurance Commissioners (NAIC)
D) The South Carolina General Assembly

Explanation: The South Carolina Department of Insurance (SCDOI) is the state regulatory body that licenses insurers and enforces state insurance laws.

34. 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.

35. Which of the following represents the correct description of proximate cause?

A) The most remote cause of a loss
B) The last event in a chain of events leading to a loss
✔ C) The dominant cause that sets in motion an unbroken chain of events leading to a loss
D) Any contributing factor in a loss

Explanation: Proximate cause is the primary or dominant cause that initiates an unbroken sequence of events that results in a loss. It determines whether a loss is covered under the policy.

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36. The 'employer mandate' under the ACA applies to applicable large employers (ALEs). An ALE is a business with:

A) Any employer that offers health benefits voluntarily
✔ B) 50 or more full-time equivalent employees
C) 25 or more full-time equivalent employees
D) 100 or more full-time equivalent employees

Explanation: Under the ACA, an Applicable Large Employer (ALE) is a business with 50 or more full-time equivalent employees (FTEs) in the prior calendar year. ALEs must offer minimum essential coverage to full-time employees and their dependents, or potentially owe an employer shared responsibility payment (employer penalty).

37. An Exclusive Provider Organization (EPO) is characterized by:

A) Providing only preventive care services
B) Covering only specialist services
C) Allowing members to use any provider nationwide
✔ D) Requiring members to use the plan's network except in emergencies, with no out-of-network coverage otherwise

Explanation: An EPO (Exclusive Provider Organization) requires members to use providers within the plan's network. Unlike a PPO, there is generally no coverage for out-of-network services except true emergencies. EPOs typically do not require a primary care physician or referrals (like an HMO does). They are essentially a restricted-network PPO.

38. Utilization review in managed care is the process of:

A) Reviewing an insured's driving record to determine health risk
✔ B) Evaluating the appropriateness and necessity of healthcare services before, during, or after care is provided
C) Reviewing a claimant's employment history to determine premium rates
D) Auditing insurance companies for regulatory compliance

Explanation: Utilization review (UR) is a systematic process used by health insurers and managed care organizations to evaluate the appropriateness and medical necessity of healthcare services. UR can occur prospectively (prior authorization before services), concurrently (during ongoing treatment), or retrospectively (after services are rendered).

39. Which ACA provision requires health plans to cover certain preventive services without any cost-sharing to the insured?

A) Essential Health Benefits mandate
B) Minimum Essential Coverage requirement
C) Medical Loss Ratio rule
✔ D) Preventive care with no cost-sharing requirement

Explanation: The ACA requires non-grandfathered health plans to cover recommended preventive services—such as immunizations, screenings, and wellness visits—without imposing deductibles, copayments, or coinsurance when provided by in-network providers.

40. In most group life insurance plans, an employee becomes eligible for coverage after completing a:

A) Series of training courses
B) Financial background check
C) Medical examination
✔ D) Waiting or probationary period

Explanation: Most group plans require new employees to complete a probationary or waiting period (commonly 30 to 90 days) before they become eligible for coverage. This requirement helps reduce administrative costs and ensures that only committed employees are enrolled.

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41. A consumer files a complaint against agent Roger for alleged fraud. Who is responsible for appointing the South Carolina Insurance Commissioner to investigate such complaints?

A) The State Senate
✔ B) The Governor of South Carolina
C) The South Carolina Department of Insurance (SCDOI) Board
D) The NAIC Board

Explanation: The South Carolina Insurance Commissioner is appointed by the Governor.

42. A policyowner can borrow from their whole life policy's cash value. What is the effect on the death benefit if the loan is not repaid?

- ✔ A) The death benefit is reduced by the outstanding loan amount plus interest.
- B) The death benefit remains unchanged.
- C) The beneficiary becomes responsible for repaying the loan.
- D) The policy is automatically terminated.

Explanation: If a policy loan is outstanding at the time of the insured's death, the insurer will deduct the loan balance plus any accrued interest from the death benefit before paying the remainder to the beneficiary.

43. An agent, Melissa, gives a prospective client a $50 gift card to convince them to purchase a life insurance policy. What is this practice called under South Carolina law?

- ✔ A) Rebating
- B) Twisting
- C) Churning
- D) Referral fee

Explanation: Giving anything of value not specified in the insurance policy to induce a purchase is rebating, which is illegal.

44. 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.

45. Under the 'fixed period' settlement option, life insurance proceeds are paid:

- A) Only if the beneficiary survives for a specified period
- B) In fixed amounts until the principal is exhausted
- ✔ C) In equal installments over a specified number of years with interest
- D) For the lifetime of the beneficiary only

Explanation: The Fixed Period (or Installments for a Fixed Period) settlement option pays the death benefit in equal installments over a specified number of years. If the beneficiary dies before the end of the period, remaining installments are paid to a named successor beneficiary. Interest is earned on the remaining balance.

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46. Which part of an insurance policy personalizes the contract with information such as the insured's name, address, and premium?

- A) Insuring Clause
- ✔ B) Declarations
- C) Exclusions
- D) Conditions

Explanation: The Declarations page contains the specific, personalized information about the policy, including the named insured, policy period, coverage amounts, premium, and property description.

47. The 'waiver of premium' provision in group life insurance typically requires the disabled employee to be:

A) Disabled for any period, however brief
✓ B) Totally and permanently disabled for at least 6 months before premiums are waived
C) Receiving government disability benefits as a condition of the waiver
D) Disabled and under age 60

Explanation: Group life insurance waiver of premium requires the employee to be totally and permanently disabled for a waiting period (typically 6 months) before premiums are waived. The waiver keeps the group life coverage in force without premium payments for the duration of the disability (or until recovery).

48. An insurer regularly offers claimants substantially less than the amounts ultimately recovered in actions brought by those claimants. What is this practice classified as?

✓ A) Unfair Claims Settlement Practice
B) Churning
C) Twisting
D) Good underwriting

Explanation: Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered is an unfair claims practice.

49. The renewability feature in term life insurance allows the policyowner to:

A) Convert the policy to an annuity at renewal
✓ B) Renew the policy for another term period without providing evidence of insurability
C) Increase the death benefit at each renewal without a new application
D) Renew only if the insured's health has improved

Explanation: A renewable term policy gives the policyowner the right to renew the coverage for another term period upon expiration without submitting evidence of insurability. However, premiums will increase at each renewal to reflect the insured's attained (current) age, making the coverage more expensive with each renewal.

50. 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.