

PRACTICE EXAM 14: TEXAS GENERAL LINES LIFE, ACCIDENT AND HEALTH SIMULATION (130 QUESTIONS)

This practice exam contains 130 questions, matching the scored length of the Texas General Lines Life, Accident and Health examination (Pearson VUE code InsTX-LAH05). Questions are distributed across the thirteen content areas in the same proportions the official September 2026 content outline specifies: 100 general knowledge questions and 30 Texas state-specific questions. Allow 150 minutes. The passing standard on the real examination is a scaled score of 70. There is no penalty for a wrong answer, so answer every question. Answers and full explanations follow the exam.

1. Premium fixed, benefit fixed, values scheduled, and the contract endows at maturity. This is:

- A. ordinary whole life insurance
- B. universal life with flexible funding
- C. annually renewable term insurance
- D. variable universal life insurance

2. Eight payments rather than a lifetime of them. The annual cost and the value growth both:

- A. fall, the burden being spread more thinly
- B. stay unchanged, only timing being altered
- C. rise, the same cost being compressed
- D. fall, with maturity arriving earlier

3. Nothing has been paid into a universal life account for four months. Coverage survives only while:

- A. the account value meets the monthly deductions
- B. the insurer's written approval remains in force
- C. the contract stays within its first decade
- D. a physician certifies inability to pay it

4. Investment direction rests with the owner, no minimum rate is promised, and payments may be varied. The product is:

- A. indexed universal life with a stated floor
- B. variable whole life with a fixed premium
- C. variable universal life
- D. interest-sensitive whole life crediting currently

5. Three young children, a modest income, and a need for the largest benefit obtainable. The answer is:

- A. twenty-pay whole life at a reduced amount
- B. universal life funded at the minimum level
- C. a single-premium contract funded by borrowing
- D. level term insurance across the dependency years

6. An outside benchmark measures the interest credited, yet the money never leaves the general account. This describes:

- A. variable universal life using subaccounts
- B. indexed life insurance
- C. participating whole life paying dividends
- D. interest-sensitive whole life crediting currently

7. A debt falls steadily to nothing across twenty-two years. The term structure that matches is:

- A. level term, holding the benefit constant
- B. annually renewable term, repriced each year
- C. decreasing term, the benefit falling on schedule
- D. return of premium term, refunding at expiry

8. Terminal illness in one spouse; funds wanted only once both are gone. The placeable contract is:

- A. joint life, priced against the poorer risk
- B. two separate single-life whole life policies
- C. annually renewable term on each life
- D. survivorship life, underwriting the healthier life

9. Every dividend buys a small parcel of paid-up coverage. Across twenty years the effect is that:

- A. the premium falling due each year drops
- B. both the benefit and the cash value grow
- C. a taxable interest credit arises annually
- D. one year of term protection is bought repeatedly

10. Forty-nine thousand went in as premiums; seventy-two thousand came back on surrender. Reportable income is:

- A. twenty-three thousand of ordinary income
- B. seventy-two thousand of ordinary income
- C. forty-nine thousand, the premiums paid
- D. nothing, insurance proceeds being exempt

11. Cover is narrowed at claim by rules found nowhere but the company's own constitution. Those rules:

- A. unenforceable, sitting outside the contract
- B. binding where the applicant acknowledged them
- C. binding where an agent explained them at sale
- D. binding once the free look has expired

12. A daughter holds a vested designation and her mother wishes to borrow. What is needed?

- A. notice to the daughter within thirty days
- B. the daughter's written consent beforehand
- C. the insurer's approval, consent being irrelevant
- D. nothing, borrowing being an owner's right

13. A four year old is the sole named beneficiary and her father has died. Payment awaits:

- A. the child reaching the age of eighteen
- B. a receipt signed by the surviving parent
- C. a one year holding period at the insurer
- D. appointment of a guardian by a court

14. Premiums ceased eleven months ago and no election was made. Coverage most probably continues as:

- A. a smaller permanent policy lasting for life
- B. nothing, the cash value having been paid out
- C. term insurance at the full original amount
- D. a reinstated contract at the original premium

15. A serious diagnosis arrives, yet more coverage can still be bought on a scheduled date. That comes from:

- A. an accidental death benefit rider
- B. a guaranteed insurability rider
- C. a cost of living rider indexing the amount
- D. a return of premium rider refunding at expiry

16. Within the examination window an owner sends her new contract back. What must be refunded?

- A. the accumulated cash value only
- B. the premium less an administrative charge
- C. nothing, coverage having been in force
- D. the whole premium, with nothing deducted

17. Nineteen thousand is owed on a loan against a ninety-five thousand dollar benefit. The beneficiary receives:

- A. seventy-six thousand, the balance deducted
- B. ninety-five thousand, loans ending at death
- C. one hundred fourteen thousand, including it
- D. ninety-five thousand, the estate owing it

18. A designation reads by the branch. A predeceased beneficiary's share therefore travels to:

- A. the surviving named beneficiaries equally
- B. the policyowner's estate for probate
- C. that beneficiary's own surviving descendants
- D. the insurer, which retains the amount

19. Death follows a long illness while an accidental death rider is in force. That rider adds:

- A. the full accidental amount alongside the base
- B. half the accidental amount as a compromise
- C. the accidental amount without the base benefit
- D. nothing, the cause not being an accident

20. Thirty-three months separate policy issue from a self-inflicted death. The settlement is:

- A. premiums refunded and no benefit paid
- B. the accumulated cash value paid instead

- C. the full death benefit, payable normally
- D. denial of the claim with premiums retained

21. The debt behind a collateral assignment is paid off. The assignee's rights now:

- A. continue until the policy matures
- B. end, the owner regaining everything
- C. convert into absolute ownership
- D. pass to the named beneficiary

22. Reinstating rather than replacing a lapsed contract costs an owner:

- A. a renewed contestable window on the coverage
- B. the original issue age and premium rate
- C. all accumulated cash value in the policy
- D. the right to name a different beneficiary

23. Aged eighty-one, no dependants, and wanting the largest monthly sum. The payout to elect is:

- A. life only, ending entirely at death
- B. life with fifteen year period certain
- C. joint and survivor with a companion
- D. an installment refund guaranteeing the outlay

24. Money went in whenever it could be spared, and income began years later. The contract is:

- A. a single premium immediate annuity
- B. a flexible premium deferred annuity
- C. a flexible premium immediate annuity
- D. a single premium deferred annuity

25. Basis has been fully returned to an annuitant who is still drawing payments. Those payments are henceforth:

- A. reduced to reflect the basis recovered
- B. exempt as a continuing return of capital
- C. fully taxable, no basis remaining
- D. split evenly between taxed and untaxed

26. Every dollar entered the plan untaxed. On distribution the taxable portion is:

- A. only the growth above contributions made
- B. nothing, the plan being federally qualified
- C. one half, the rest being return of capital
- D. the entire amount, no basis having arisen

27. Deduction forgone today buys untaxed qualified withdrawals tomorrow. The arrangement is:

- A. a Roth individual retirement arrangement
- B. a traditional individual retirement arrangement
- C. a section 403(b) tax-sheltered annuity
- D. a section 457 deferred compensation plan

28. Eleven owners each insure the other ten personally. Contracts required number:

- A. eleven, one on each owner's life
- B. one hundred ten in total
- C. one hundred twenty-one altogether
- D. twenty-two, two on each owner

29. A firm owns, funds, and benefits from cover on its finance director. Death proceeds arrive:

- A. taxable as ordinary business income
- B. taxable only above premiums paid in
- C. free of income tax, premiums being non-deductible
- D. shared with the director's surviving estate

30. Survivor payments stop at the child's qualifying age and resume at the spouse's retirement. That gap is:

- A. the elimination period before benefits begin
- B. the probationary period at a policy's start
- C. the blackout period, nothing being payable
- D. the contestable period for denying claims

31. A veterinarian cannot operate but could lecture, and her policy uses an any occupation standard. She is:

- A. totally disabled, her own duties being impossible
- B. residually disabled, paid in proportion to earnings
- C. presumptively disabled, benefits starting at once
- D. not disabled, suitable alternative work existing

32. Earnings drop from twenty-four thousand to eighteen thousand monthly. A residual provision paying sixteen thousand yields:

- A. four thousand, one quarter of the benefit
- B. six thousand, matching the earnings lost
- C. sixteen thousand, the full monthly benefit
- D. eight thousand, half of the full benefit

33. Disability lasted sixty days; the waiting requirement was ninety. The benefit payable is:

- A. benefits for the final thirty days
- B. nothing, the requirement never being met
- C. benefits paid retroactively from onset
- D. half benefits across the whole period

34. The use of both arms is lost and payments start at once with no waiting. That comes from:

- A. a recurrent disability provision
- B. a residual disability provision
- C. an own occupation definition of disability
- D. a presumptive disability provision

35. A disabled owner's surgery keeps paying rent and nurses' wages, but nothing to her personally. The policy is:

- A. individual disability income insurance
- B. key employee disability insurance
- C. a disability buy-sell funding contract
- D. business overhead expense insurance

36. Twenty-two thousand of covered charges. Three thousand of deductible. Four fifths met by the plan. The member owes:

- A. three thousand, being the deductible alone
- B. four thousand four hundred, a fifth of charges
- C. six thousand eight hundred in total
- D. three thousand eight hundred, a fifth after

37. Thirty dollars is charged at every visit whatever the bill behind it. That charge is:

- A. coinsurance, a percentage of the charge
- B. a copayment, fixed per service delivered
- C. a deductible, paid before benefits begin
- D. an out-of-pocket maximum for the year

38. Nothing is paid beyond the panel except emergencies, and a nominated doctor must refer throughout. This is:

- A. a health maintenance organization
- B. a preferred provider organization
- C. a point of service plan
- D. an indemnity plan paying per day

39. Contracted doctors keep treating their own private patients alongside plan members. The model is:

- A. a staff model with salaried physicians
- B. a group model contracting one practice
- C. a network model contracting several groups
- D. an independent practice association

40. A high deductible plan is required, the individual owns it, and balances never expire. The account is:

- A. a health savings account
- B. a flexible spending account
- C. a health reimbursement arrangement
- D. a section 125 cafeteria plan

41. Someone medically stable needs help washing and dressing. That level of care is called:

- A. skilled nursing care ordered by a physician
- B. custodial care, needing no medical training

- C. intermediate care delivered occasionally
- D. respite care relieving an unpaid caregiver

42. An insured with dementia dresses and feeds herself without help. Her long-term care policy pays because:

- A. two daily activities are deemed lost automatically
- B. ninety days of confinement have been completed
- C. cognitive impairment triggers benefits independently
- D. a physician has certified a terminal prognosis

43. Arthritis is the stated reason for refusing a supplement two months into Part B at sixty-six. The refusal is:

- A. lawful, supplements being medically underwritten
- B. unlawful, open enrollment guaranteeing issue
- C. lawful where another lettered plan is offered
- D. lawful where the diagnosis is recent

44. A covered employee dies. Continuation for the dependents then runs:

- A. thirty-six months from the qualifying event
- B. eighteen months from the qualifying event
- C. twenty-nine months from the qualifying event
- D. twelve months from the qualifying event

45. The employer meets the whole group health premium. Insurers therefore expect enrollment of:

- A. seventy-five percent of eligible employees
- B. fifty percent of eligible employees
- C. no stated minimum at all

D. one hundred percent of eligible employees

46. Notice of claim went in three weeks ago and no forms have come back. The claimant may:

- A. treat the claim as approved and demand payment
- B. recover a statutory penalty from the insurer
- C. put in written proof of loss in any form
- D. wait indefinitely without prejudicing anything

47. Illness arrives on day six after a lapsed health contract was reinstated. The claim is:

- A. denied, sickness being covered after ten days
- B. paid in full, coverage having been restored
- C. paid at half benefit for the first month
- D. denied permanently as a preexisting condition

48. An insured switched to riskier work in silence, then claimed. The insurer will:

- A. void the policy from the date of the change
- B. deny the claim for want of proper notice
- C. reduce benefits to what the premium bought
- D. pay in full and invoice the difference

49. Loss suffered while intoxicated may be excluded. That exclusion sits among:

- A. the mandatory provisions protecting the insured
- B. the nonforfeiture provisions preserving value
- C. the entire contract provision limiting documents
- D. the optional provisions protecting the insurer

50. Mid-term termination on notice, plus freedom to reprice, belongs to which classification?

- A. guaranteed renewable, permitting class increases
- B. cancelable, the widest discretion of all
- C. optionally renewable, declining at renewal dates
- D. noncancelable, locking renewal and premium

51. A member's yearly spending ceiling is reached in April. Covered charges thereafter are:

- A. still subject to the coinsurance percentage
- B. subject to a second annual deductible
- C. met in full by the plan for the year
- D. paid at half the ordinary benefit level

52. Specialists seen unaided, and something still paid beyond the panel. That belongs to:

- A. a health maintenance organization using a gatekeeper
- B. a preferred provider organization network
- C. a point of service plan requiring referral
- D. an indemnity plan paying a fixed daily sum

53. Utilization staff assess a stay's necessity mid-admission. That review is described as:

- A. precertification, applied before treatment begins
- B. retrospective review, applied after discharge
- C. capitation, paying a fixed monthly amount
- D. concurrent review, applied during the stay

54. Employer money alone funds it, and nothing follows the worker out of the door. That is:

- A. a health reimbursement arrangement
- B. a health savings account owned individually
- C. a flexible spending account by salary reduction
- D. a Roth individual retirement arrangement

55. A fortnight of relief for an exhausted unpaid carer is bought by which benefit?

- A. skilled nursing care ordered by a physician
- B. adult day care attended during working hours
- C. respite care within a long-term care policy
- D. home health care delivered continuously

56. A gap of sixty-five days sits between discharge and readmission for a Medicare patient. Consequently:

- A. the existing benefit period simply continues
- B. a new benefit period opens with a new deductible
- C. lifetime reserve days are drawn upon at once
- D. the readmission falls outside coverage entirely

57. Four fifths paid after the deductible, and no ceiling on the beneficiary's remaining fifth. This is:

- A. Part B, covering physician and outpatient care
- B. Part A, covering inpatient hospital services
- C. Part D, covering outpatient prescription drugs
- D. Part C, replacing Original Medicare entirely

58. Two conditions let a disabled worker reach Medicare without waiting two years. They are:

- A. chronic obstructive pulmonary disease and emphysema
- B. congestive heart failure and advanced dementia

- C. any cancer requiring chemotherapy and total blindness
- D. end-stage renal disease and amyotrophic lateral sclerosis

59. What a person owns, rather than credits worked, opens the door to which program?

- A. Medicare Part A hospital insurance
- B. Medicare Part B medical insurance
- C. Social Security retirement benefits
- D. Medicaid, a needs-based program

60. One parent was born 3 January, the other 28 July. Their daughter's primary plan is:

- A. the July parent's, being the later date
- B. the January parent's, being the earlier date
- C. whichever the parents nominate together
- D. both equally, each meeting half of claims

61. Nine hundred was paid by the first plan; the second would have paid seven hundred alone. Nonduplication leaves it owing:

- A. its full ordinary benefit regardless
- B. the difference between the two figures
- C. nothing toward that particular claim
- D. half of what it would otherwise pay

62. An injury at work brings nothing from the private policy. That policy was written:

- A. on a non-occupational basis
- B. on an occupational or twenty-four-hour basis
- C. as a guaranteed renewable contract
- D. with a probationary period attached

63. Benefits without proving fault, in exchange for surrendering the right to sue. That bargain is:

- A. the exclusive remedy in workers compensation
- B. subrogation following payment of a claim
- C. coordination of benefits between two plans
- D. the relation of earnings to insurance provision

64. An at-fault motorist is pursued for the sum a plan already paid its member. That right is:

- A. coordination of benefits between two plans
- B. subrogation against the responsible party
- C. nonduplication of overlapping coverage held
- D. the relation of earnings to insurance provision

65. Something noticed at interview cannot be captured by the form. It belongs in:

- A. a note initialed on the application itself
- B. a telephone call to the underwriting department
- C. the agent's report, unseen by the applicant
- D. a letter to the applicant's own physician

66. Corrections made to a signed application become valid on whose authority?

- A. the agent's initials recording the correction
- B. a countersignature from the supervising agency
- C. nothing further, the entry now being accurate
- D. the applicant's own initials beside it

67. Insurability as a standard risk is the condition attached to which premium receipt?

- A. the policy is physically delivered afterward
- B. the applicant proves insurable as a standard risk
- C. the underwriter approves the completed file
- D. a stated number of days has elapsed

68. Funding by an outsider, no demonstrated need, and ownership passing soon after issue. Together these mark:

- A. an ordinary collateral assignment for value
- B. a lawful third-party ownership arrangement
- C. a stranger-originated arrangement to be refused
- D. a permissible viatical settlement transaction

69. Coded findings from member insurers, never sufficient alone to decline, come from:

- A. an attending physician statement obtained
- B. an inspection report from a consumer agency
- C. a paramedical examination the insurer ordered
- D. the member-insurer information exchange

70. Written warning that a report may be obtained is compelled by which statute?

- A. the Fair Credit Reporting Act
- B. the Gramm-Leach-Bliley privacy requirements
- C. the anti-money laundering program rules
- D. the Health Insurance Portability and Accountability Act

71. Client premium rested in an agent's personal account from Friday until Monday. That is:

- A. acceptable, the funds having been remitted after
- B. acceptable, no interest having accrued to her
- C. commingling, prohibited whatever the outcome
- D. a matter concerning only her and the insurer

72. Figures more cautious than the insurer's own, circulated by an agent, amount to:

- A. acceptable, conservative figures protecting the client
- B. acceptable where she signs and dates it
- C. objectionable only where figures are inflated
- D. prohibited, the illustration being the insurer's own

73. A replacement is urged on nothing but a lower monthly figure. The agent's conduct amounts to:

- A. twisting, the comparison being incomplete
- B. nothing, price being the client's concern
- C. nothing, the policy disclosing the remainder
- D. churning, since commission is earned again

74. Clients are switched repeatedly inside one insurer's book and gain nothing by it. That is:

- A. twisting, involving false statements about coverage
- B. churning, defined by the absence of benefit
- C. rebating, conferring an unlawful inducement
- D. commingling, involving the misuse of funds

75. A client asks his agent to put part of her commission toward his premium. Complying is:

- A. acceptable where the insurer is told in writing
- B. rebating, prohibited in every circumstance
- C. acceptable where the sum is genuinely nominal

D. acceptable because the client initiated it

76. Seven classroom hours sit within a Texas producer's completed twenty-four. She is:

- A. five hours short of the classroom minimum
- B. compliant, the overall total being met
- C. compliant provided three hours were ethics
- D. five hours in excess of the requirement

77. Ten months beyond expiry, a Texas producer wants to work again. Her route is:

- A. late renewal on payment of an additional fee
- B. continuing to work while an application processes
- C. reinstatement, without retaking the examination
- D. waiting for the next renewal cycle to open

78. A sponsoring company must put its temporary licensee through forty hours. That obligation matures:

- A. ninety days after the license application
- B. one hundred eighty days after the application
- C. sixty days after the appointment is filed
- D. thirty days after the license application

79. Twenty-one months elapsed between passing in Texas and applying. The consequence is that she must:

- A. sit the examination once more before applying
- B. pay a late filing penalty with the application
- C. complete forty hours of pre-licensing education
- D. obtain a written waiver from the Commissioner

80. Incorporation took place in Germany and admission was granted in Texas. The classification is:

- A. foreign, being organized outside this state
- B. domestic, once admission has been granted
- C. unauthorized until an office opens here
- D. alien, being organized outside the United States

81. No appointment has been filed, yet an agent writes business for that company. She is:

- A. safe, her license covering that line of business
- B. in violation, appointment preceding any selling
- C. safe for ninety days pending the filing
- D. safe where the company is admitted in Texas

82. Failed insurer, one hundred thirty thousand of surrender values. Association cover extends to:

- A. one hundred thirty thousand, matching the values
- B. three hundred thousand, the death benefit limit
- C. one hundred thousand, the surrender value limit
- D. two hundred fifty thousand, the annuity limit

83. Guaranty association backing is invoked to settle a Texas prospect's nerves. That use is:

- A. prohibited in every form of presentation
- B. permitted where the limits are stated accurately
- C. permitted where the insurer's rating is weak
- D. permitted in writing though not in conversation

84. A Texas grace period stated in days must not fall below:

- A. ten days after the premium falls due
- B. twenty days after the premium falls due
- C. thirty-one days after the premium falls due
- D. sixty days after the premium falls due

85. Sixteen months into a Texas contract a material misstatement comes to light. The insurer may:

- A. do nothing, the incontestable period having run
- B. contest, two years not yet having elapsed
- C. contest only for nonpayment of the premium
- D. reduce the benefit rather than contest at all

86. Twenty-nine months of premiums lie behind a Texas loan request on a permanent contract. The insurer:

- A. must lend, cash value being present already
- B. must lend at a rate fixed by the statute
- C. must lend only where the policy participates
- D. need not lend, three full years being required

87. The insured turns out to have been three years younger than the application stated. A Texas insurer will:

- A. refused entirely for material misrepresentation
- B. paid in full with the shortfall invoiced
- C. adjusted to what the premium actually purchased
- D. voided, with all premiums returned instead

88. Every sentence of an advertisement is true, but the reader is left misled. The advertisement is:

- A. acceptable, since no statement is untrue

- B. acceptable once the Commissioner approves it
- C. acceptable where a disclaimer appears somewhere
- D. misleading, by the overall impression created

89. Delivery of the Buyer's Guide came only with the Texas annuity contract itself. The free look is:

- A. ten calendar days from the contract's issue
- B. fifteen calendar days from receiving the contract
- C. twenty calendar days from the application
- D. thirty calendar days from the contract's issue

90. Face amount trimmed on an old Texas contract so a new one becomes affordable. This counts as:

- A. a replacement, reduction in value being caught
- B. no replacement, the old policy continuing
- C. no replacement, nothing having been surrendered
- D. a replacement only where the insurer is the same

91. Which company hears from the replacing insurer the moment a Texas replacement begins?

- A. the guaranty association covering the insured
- B. the agent's other appointing insurers of record
- C. the Department, for prior approval of the sale
- D. the existing insurer whose policy is replaced

92. Minimum values and a printed year-by-year table are imposed on Texas permanent contracts by:

- A. the incontestability requirement in the Code
- B. the Standard Nonforfeiture Law
- C. the free look attached to policy delivery
- D. the entire contract provision limiting documents

93. A Texas group member converts on leaving employment. Her new premium reflects:

- A. her attained age at the date of conversion
- B. the age at which she first joined the group
- C. a rate published in a Department table
- D. the average age of the group being left

94. Debt secured, credit life taken alongside. The permissible sum insured is capped at:

- A. the borrower's own stated wishes at closing
- B. twice the outstanding balance of the loan
- C. the amount of the indebtedness itself
- D. a fixed statutory ceiling on all such policies

95. Hours after birth a Texas infant needs an operation. The dependent plan's cover started:

- A. once an enrollment form was submitted
- B. at the start of the next plan month
- C. at birth, with no prior enrollment needed
- D. once the additional premium was received

96. Age and claims history stand where among grounds for non-renewing a Texas supplement?

- A. the insured's advancing age or heavy claiming
- B. nonpayment of the premium when it fell due
- C. material misrepresentation made at application
- D. fraud discovered after the policy was issued

97. Before drawing blood for an HIV test in Texas, what document must the insurer hold?

- A. the general medical authorization already signed
- B. separate written informed consent for that test
- C. verbal agreement noted in the underwriting file
- D. consent obtained from the applicant's physician

98. Thirty-three employees, a poor claims record, and a Texas group application. The carrier is obliged to:

- A. decline, the concentration of risk being excessive
- B. issue only after a twelve month waiting period
- C. issue at a premium reflecting that claims record
- D. issue any plan it offers, guaranteed issue applying

99. Participation and contribution shortfalls occupy what position under Texas guaranteed issue?

- A. the health status of its least healthy worker
- B. the group's claims experience over three years
- C. failure to meet participation or contribution rules
- D. the employer having changed carriers recently

100. A member walks out of a routine in-network screening with no bill. The reason is that:

- A. her deductible had already been satisfied
- B. the provider waived the charge as a courtesy
- C. screenings are excluded from the plan entirely
- D. required preventive services carry no cost sharing

101. A Texas producer adds a second license type. Her education obligation thereafter:

- A. remains twenty-four hours covering both
- B. doubles to forty-eight hours in the period
- C. rises by half, to thirty-six hours
- D. alternates, twenty-four for each in turn

102. Six hours of the requirement went uncompleted. The Department's response is:

- A. immediate revocation of the license held
- B. a fine calculated for each hour outstanding
- C. a written warning carrying no penalty
- D. suspension until the following renewal

103. A new office address reached the appointing insurer but never the Department. The producer is:

- A. compliant, the insurer having been told
- B. free to update the record at renewal
- C. under no duty, no address being licensed
- D. in breach of the thirty day reporting rule

104. Insurance statutes in Texas originate with which body?

- A. the Department, through its rulemaking authority
- B. the Legislature, exercising legislative power
- C. the courts, through binding precedent
- D. the guaranty association, by member vote

105. An unlicensed friend introduced a client and now wants a share of the commission. She may receive:

- A. nothing, licensed persons alone being eligible
- B. a nominal referral fee without difficulty

- C. a share where the client consents in writing
- D. a share where she sold nothing herself

106. Same age, same health, same occupation, different quotes from one carrier. That is:

- A. lawful individual underwriting of each case
- B. rebating, one applicant gaining an advantage
- C. unfair discrimination within a single class
- D. nothing improper, both quotes being honest

107. An insolvency strands three hundred forty thousand of annuity present value in Texas. Cover runs to:

- A. two hundred fifty thousand, the annuity limit
- B. three hundred forty thousand, matching the value
- C. three hundred thousand, the death benefit limit
- D. one hundred thousand, the surrender value limit

108. Among the Texas guaranty categories, which is protected to the largest figure?

- A. life insurance death benefits payable
- B. basic hospital, medical-surgical, and major medical
- C. long-term disability and long-term care benefits
- D. other supplemental health, including Medicare supplement

109. Association backing is raised to reassure a wavering Texas prospect. That reinsurance is:

- A. permitted where the limits are given accurately
- B. permitted where the insurer's rating is weak
- C. prohibited in every form of presentation
- D. permitted verbally though not in writing

110. A Texas insurer wishes to levy interest on premium overdue in the grace month. That requires:

- A. the Commissioner has approved that rate
- B. the policyowner consented at the time of issue
- C. the grace period runs beyond a calendar month
- D. the contract itself specifies the rate applied

111. Eight months have run when an application falsehood surfaces on a Texas policy. The company:

- A. do nothing, the two year period having run
- B. contest, the incontestable period being incomplete
- C. contest only for nonpayment of the premium
- D. reduce the benefit rather than contest at all

112. Term cover in Texas has thrown off some cash value. Borrowing rights arising are:

- A. immediate, upon the value first appearing
- B. available once three years of premiums are paid
- C. available where the contract is participating
- D. absent, term contracts being exempt from the rule

113. General reading on how life insurance works has reached a Texas buyer. Still outstanding is:

- A. a summary of the particular policy offered
- B. the insurer's audited financial statements
- C. a schedule of the agent's commission earnings
- D. an illustration guaranteeing projected values

114. Projected figures are described to a Texas prospect as amounts certain to be paid. The defect is that:

- A. nothing, where the insurer prepared the document
- B. nothing, once the prospect signs a receipt
- C. non-guaranteed values are presented as certain
- D. nothing, for the guaranteed column of figures

115. One Texas contract is surrendered so another elsewhere can be bought. The producer's first duty is:

- A. obtaining the existing insurer's written consent
- B. presenting the replacement notice and taking signatures
- C. delaying the application by sixty days
- D. submitting the transaction to the Department

116. Nonforfeiture figures set out in statute operate as a floor. The practical consequence for a Texas insurer is that it:

- A. the Commissioner permits annual adjustments
- B. policyowners may agree to variations in writing
- C. the table applies only after ten policy years
- D. the statute prescribes minimums rather than fixed sums

117. Evidence of health, demanded of a departing Texas group member wishing to convert, is:

- A. always required before conversion proceeds
- B. required only where coverage ran under ten years
- C. never required within the conversion window
- D. required only where the group policy continues

118. Credit life made a precondition of lending in Texas is:

- A. unlawful, such cover not being requirable
- B. lawful, the lender bearing the credit risk
- C. lawful where the borrower signs a disclosure
- D. lawful where the sum matches the indebtedness

119. Re-verification of a disabled adult child's dependency may occur in Texas how often?

- A. at any time and as often as it wishes
- B. periodically, but no more than once a year
- C. once only, when the limiting age is reached
- D. only where the plan is a group arrangement

120. Historically excluded or narrowly covered, which treatment must Texas plans now fund as a mandate?

- A. cosmetic surgery performed by a specialist
- B. long-term custodial nursing facility care
- C. experimental therapies not generally accepted
- D. necessary care for chemical dependency

121. Underwriting built on inferences drawn from a Texas applicant's household is:

- A. prohibited, proxies never being usable to infer it
- B. permitted where a consented test supports it
- C. permitted where actuarial evidence justifies it
- D. permitted where the applicant is told in writing

122. Seventy-four eligible workers place a Texas employer:

- A. inside the small employer band, guaranteed issue applying
- B. inside it where a majority of workers enroll

- C. outside the band, negotiating on commercial terms
- D. outside it only where cover was held before

123. Advance notice plus a multi-year bar on returning is the price paid by:

- A. an insurer surrendering its certificate of authority
- B. an agent whose license has been revoked
- C. a carrier changing its rating methodology
- D. a carrier leaving the small employer market

124. An eligible Texas household sees its monthly Marketplace cost fall through:

- A. a cost-sharing reduction tied to a designated tier
- B. the premium tax credit, advanced or claimed later
- C. a state subsidy administered by the Department
- D. an employer contribution required by federal law

125. Which of the defined benefit categories carries counseling and addiction treatment within it?

- A. mental health and substance use disorder services
- B. adult routine dental and orthodontic treatment
- C. long-term custodial nursing facility care
- D. elective procedures undertaken for appearance

126. Reporting duties and payment exposure under federal reform rest upon:

- A. every employer regardless of workforce size
- B. employers buying through the Marketplace only
- C. applicable large employers as federally defined
- D. employers offering self-funded arrangements only

127. Which HMO document requires Departmental clearance before an enrollee receives it?

- A. a certificate under a group master contract
- B. an evidence of coverage
- C. a policy summary delivered with the contract
- D. a binding receipt dated from application

128. Utilization, health status, and complaints filed stand where among Texas non-renewal grounds?

- A. none, all three being impermissible
- B. all three are legitimate on notice
- C. only utilization is impermissible
- D. only complaints filed are impermissible

129. Collapse far from the network, treatment at the nearest hospital. Texas requires the care be:

- A. denied absent prior authorization from the HMO
- B. reimbursed at half the in-network benefit
- C. paid personally and reclaimed at renewal
- D. covered without regard to network status

130. Personal use of premium money, repaid within a day, exposes a Texas agent to:

- A. no action, restitution having been prompt
- B. a warning only, given the short duration
- C. revocation, the use amounting to conversion
- D. action only where a policyholder lost money

Practice Exam 14: Answer Key and Explanations

1. **A** — Whole life guarantees a level premium, a level death benefit, and a schedule of cash values, and it endows at maturity when cash value reaches the face amount. Term never endows, universal life fixes no premium, and variable products guarantee very little at all. Guarantees define the whole life form throughout.
2. **C** — Limited-pay whole life compresses the same lifetime cost into fewer payments, so each annual premium is larger while the accelerated funding builds cash value more quickly. The face amount and maturity age never change, since only the schedule differs between them. The face amount and maturity age stay constant. Accelerated funding is what builds value faster here.
3. **A** — Universal life separates the components, so a premium may be skipped whenever the accumulated account value covers the monthly cost of insurance and expense deductions. Once the account is exhausted the policy lapses, however permanent the owner believed it to be. Underfunding produces lapse rather than conversion. Owners believing coverage permanent are frequently caught out.
4. **C** — Variable universal life combines separate account investment with universal life's flexible premium, producing the least guaranteed product in common use, since neither premium nor cash value nor anything beyond a minimum death benefit is fixed at all. Variable whole life keeps a fixed premium instead. Nothing beyond a minimum death benefit is fixed.
5. **D** — Term insurance builds no cash value and provides pure protection, so every premium dollar beyond expenses buys mortality coverage and the affordable face amount is the largest available. Cutting the amount to afford permanence underinsures the family when exposure peaks. Underinsuring during dependency is the real risk. Every premium dollar beyond expenses buys mortality cover.
6. **B** — An indexed policy credits interest by reference to an external index while the insurer retains the funds in its general account, using the index purely as a measuring device. Because no direct investment occurs, indexed products generally are not securities. Variable products place funds in separate accounts. Indexed products generally are not securities at all.
7. **C** — Decreasing term holds the premium level while the death benefit declines on a schedule that can be matched to an amortizing balance, which is why mortgage protection is the classic application. Level term costs more than the need actually requires. Level term keeps the benefit constant regardless. Mortgage protection is the classic application of it.
8. **D** — Because survivorship life defers payment until both insureds have died, the healthier life carries most of the expected cost and underwriting is relaxed enough to cover a couple where one spouse is seriously impaired. Joint life would likely decline outright. Joint life would price against the poorer risk. The healthier life carries most of the expected cost.
9. **B** — Paid-up additions apply each dividend as a single premium to purchase small increments of permanent coverage, and because each increment is itself insurance carrying its own value, both the death benefit and the cash value grow steadily over time. Dividends remain a nontaxable return of premium. Each increment is itself insurance carrying its own value.

10. A — On full surrender, any amount received above the total premiums paid is taxable as ordinary income, so the reportable gain is twenty-three thousand. Only death proceeds are generally received income-tax-free, and capital gain treatment never applies to a surrender. A long-held policy can produce a substantial bill. Only death proceeds are generally received tax-free.

11. A — The entire contract comprises the policy, the attached copy of the application, and any riders or endorsements, so bylaws cannot be incorporated by reference. No change binds the insurer unless made in writing and approved by an executive officer. Attached documents alone constitute the agreement. Nothing binds unless an executive officer approves it.

12. B — An irrevocable beneficiary holds a vested interest, so consent is required to change the designation and also to take a policy loan, assign the contract, or surrender it. The restriction is genuine, which explains its use in divorce settlements. Such designations commonly follow divorce settlements. Consent covers loans, assignments, and surrenders alike.

13. D — Insurers will not pay policy proceeds directly to a minor, so a court-appointed guardian must be arranged before payment, delaying settlement and imposing cost on the family. A trust or custodial arrangement named at issue avoids that difficulty. Delay and cost fall on the surviving family. A trust named at issue avoids that difficulty cleanly.

14. C — Extended term is ordinarily the automatic nonforfeiture option where the owner makes no election, applying cash value to buy term insurance at the full original face amount for as long as that value will fund. Reduced paid-up requires an election. Reduced paid-up and surrender both require election. Cash value funds that term cover while it lasts.

15. B — Guaranteed insurability permits the purchase of additional coverage at specified future dates or life events without evidence of insurability, so its value is realized precisely by someone whose health has since deteriorated badly indeed. Scheduled dates or life events govern the right. Health that has since deteriorated is exactly the point.

16. D — The free look gives the owner a stated number of days after delivery to examine the contract and return it for a full refund with no obligation and no deduction. The period runs from delivery rather than from the issue date. A signed delivery receipt records that date. No deduction of any kind may be made.

17. A — An outstanding policy loan plus accrued interest is deducted from the death benefit when the insured dies, so the beneficiary receives the face amount reduced by the balance owed. Neither the beneficiary nor the estate becomes personally liable for repayment. The insurer neither forgives nor adds the loan. Accrued interest is deducted along with the principal.

18. C — Per stirpes means by the branch, so a deceased beneficiary's share flows down to that person's own descendants rather than being redistributed. Per capita, by the head, divides it among the surviving named beneficiaries instead of the descendants. The two designations produce opposite family outcomes. Per capita would redistribute among the survivors instead.

19. D — An accidental death rider pays its additional amount only where death results from accident within a stated period following it. Death from illness triggers the base policy alone, so the beneficiary receives the face amount without any addition. Causation between accident and death must be shown. The base policy alone responds in that situation.

20. C — The suicide clause conventionally runs two years from issue, and a death at thirty-three months falls beyond it. Suicide is then treated as any other cause and the full benefit is payable. Within the period premiums would be refunded instead. Two years from issue is the conventional boundary. Within the period premiums are refunded instead.

21. B — A collateral assignment transfers policy rights only to the extent of a debt and ends once that debt is satisfied, with full rights returning to the owner. An absolute assignment instead transfers ownership permanently to the assignee who then controls it. The assignee otherwise controls the entire contract. An absolute assignment would transfer ownership permanently.

22. A — Reinstatement restores the original contract, preserving issue age and premium, but a fresh contestable period begins on the reinstated coverage, so the insurer regains a window to contest statements made in the reinstatement application itself. Purchasing afresh at current age is the alternative. The reinstatement application statements become contestable afresh.

23. A — Life only pays for as long as the annuitant lives and stops at death, producing the largest periodic payment because the insurer assumes no obligation beyond that single life. No dependant exists to protect in this particular case. Survivor guarantees always reduce the periodic payment. The insurer assumes no obligation beyond that life.

24. B — Flexible premium funding accepts varying contributions over time, which is incompatible with immediate payout because payments cannot begin while funding continues. Flexible premium annuities are therefore always deferred, and the immediate combination cannot exist at all. Funding must be complete before payments begin. Payments cannot begin while funding still continues.

25. C — The exclusion ratio spreads the investment in the contract across the expected number of payments. Once basis has been fully recovered, nothing remains to exclude and every later payment is entirely taxable as gain going forward. Only the tax treatment changes, not the amount. Every later payment is entirely taxable as gain.

26. D — Qualified plan contributions are made with pre-tax dollars, so the participant has no basis and the entire distribution is taxable as ordinary income rather than only the growth. Nonqualified arrangements create basis and tax the gain alone. Nonqualified arrangements tax only the gain portion. The participant holds no basis to recover.

27. A — A Roth arrangement is funded with after-tax dollars, so contributions are not deductible, but qualified distributions including all accumulated growth are received free of income tax. It taxes at the front rather than at distribution time. Traditional arrangements reverse that ordering entirely. Qualified distributions include all the accumulated growth. Tax is paid at the front instead.

28. B — Under cross-purchase each owner insures every other owner, so eleven owners require eleven multiplied by ten, giving one hundred ten policies. The number grows steeply as owners are added, which is why larger firms prefer entity arrangements. Entity arrangements scale far more practically instead. Eleven owners insuring ten others produces one hundred ten.

29. C — Key person insurance names the business as owner, payer, and beneficiary. Premiums are not deductible as a business expense, and the corresponding benefit is that death proceeds are received free of income tax by that business. Overhead expense coverage reverses that treatment. Premiums are not deductible, which produces that result.

30. C — Benefits to a surviving spouse caring for the deceased worker's child cease when the youngest child reaches the qualifying age and do not resume until retirement age. That interval is the blackout period, and private coverage exists to fill it. Decades may elapse before benefits resume again. Private coverage exists to fill precisely that gap.

31. D — Any occupation asks whether the insured can work in any field for which they are reasonably suited by education, training, and experience, so a claimant able to lecture is not disabled. Own occupation would reverse that result entirely. Definition rather than diagnosis decides the claim. Education, training, and experience define suitable work.

32. A — Income loss is six thousand against prior earnings of twenty-four thousand, which is one quarter. Applying that proportion to the sixteen thousand full benefit produces four thousand. Residual provisions pay in proportion to income lost. Proportion rather than raw shortfall governs the sum. One quarter lost yields one quarter of benefit.

33. B — The elimination period functions as a deductible measured in time, running from the onset of disability, and benefits begin only once it is fully satisfied. A disability ending at sixty days never reaches the ninety day threshold. Nothing is paid retroactively across the period. The elimination period is a deductible measured in time.

34. D — Presumptive disability provisions deem the insured totally disabled on specified catastrophic losses such as sight in both eyes, hearing in both ears, speech, or the use of two limbs. Benefits typically begin immediately without any waiting period. No proof of inability to work is required. Catastrophic losses settle the question by themselves.

35. D — Business overhead expense reimburses the continuing costs of keeping a business open while the owner is disabled, covering rent, utilities, staff salaries, and equipment leases, but excluding the owner's own salary or draw entirely from cover. The owner's own income needs separate coverage. Rent, utilities, and equipment leases are all covered.

36. C — The member pays the three thousand deductible first, leaving nineteen thousand subject to coinsurance. Twenty percent of nineteen thousand is three thousand eight hundred, so the total is six thousand eight hundred and the plan pays the balance. Order of operations decides the calculation entirely. Applying coinsurance before the deductible is the planted error.

37. B — A copayment is a flat charge per service, such as a set amount per office visit, while coinsurance is a percentage of the covered charge after the deductible. The deductible precedes benefits and the maximum caps annual exposure. Percentages and flat charges operate differently here. Coinsurance instead takes a percentage after the deductible.

38. A — An HMO requires members to select a primary care physician acting as gatekeeper who refers to specialists, and it generally covers nothing obtained outside the network except in an emergency. A point of service plan covers outside care. Emergencies form the single recognized exception. A point of service plan covers outside care.

39. D — An independent practice association contracts with physicians who continue their own private practices and also treat patients who are not members. A staff model employs physicians directly, and a group model contracts one multi-specialty group. Each model offers a different degree of choice. A staff model employs its physicians directly instead.

40. A — A health savings account must be paired with a qualifying high deductible health plan, belongs to the individual so it is portable, and rolls unused balances over indefinitely. Reimbursement arrangements are employer-owned and not portable at all. Spending accounts generally forfeit unused balances instead. Portability distinguishes it from the employer-owned arrangements.

41. B — Custodial care assists with the ordinary activities of living and requires no medical training to provide. It is covered by neither Medicare nor major medical insurance, which is precisely why long-term care policies exist in the first place. Medicare excludes custodial care at every level. Long-term care policies exist because it goes uncovered.

42. C — Severe cognitive impairment is an independent benefit trigger, so an insured with advanced dementia may qualify while remaining physically able to perform every activity of daily living. The alternative trigger requires losing a stated number of activities. Two of six activities is the alternative trigger. Losing two of six activities is the alternative.

43. B — The one-time Medigap open enrollment period begins when the beneficiary is both sixty-five or older and enrolled in Part B, running six months. During it the insurer must issue any plan it offers regardless of health. Six months from Part B enrollment is the window. The insurer must issue any plan it offers.

44. A — Death of the covered employee is a thirty-six month qualifying event for dependents, as are divorce or legal separation, a dependent child ceasing to qualify, and the employee becoming entitled to Medicare. Termination gives eighteen months instead. Termination and reduced hours give eighteen instead. Divorce and loss of dependent status match it.

45. D — A noncontributory plan is paid entirely by the employer, and because no employee declines free coverage, insurers ordinarily require one hundred percent participation. Contributory plans accept a lower threshold, commonly seventy-five percent of those eligible. Both thresholds guard against adverse selection. Free coverage that nobody declines explains that rule. Adverse selection is thereby prevented.

46. C — Where the insurer fails to furnish claim forms within fifteen days of receiving notice, the insured may submit written proof of the occurrence, character, and extent of the loss in any form, and the insurer must accept it. Its own delay cannot defeat the claim. The insurer's own delay cannot prejudice a claimant.

47. A — On reinstatement of a health policy, accidents are covered immediately but sickness only after ten days. The gap exists to prevent someone reinstating a lapsed policy because they have already begun to feel unwell, and day six falls inside that window. Accidents by contrast are covered immediately. Reinstatement covers accidents at once but delays sickness.

48. C — Change of occupation is a proportionality remedy rather than a forfeiture. Moving to more hazardous work reduces benefits to what the premium paid would have purchased at that higher-risk rate. The insurer does not deny, bill the difference, or void it. Notification failure does not forfeit the coverage. Proportionality rather than forfeiture governs that outcome.

49. D — The intoxicants and narcotics provision is optional and permits exclusion of loss sustained while the insured was intoxicated or under the influence of narcotics other than as administered on a physician's advice. Mandatory provisions protect the insured instead. Medication taken as prescribed is not caught. Sorting mandatory from optional provisions is itself tested.

50. B — A cancelable classification permits the insurer to terminate coverage mid-term on notice and to change the premium, giving it the greatest discretion of any classification. Noncancelable locks both renewal and premium, sitting at the opposite end entirely. The classifications form a spectrum of protection. Noncancelable sits at the opposite end entirely.

51. C — The out-of-pocket maximum caps what a member pays in a year, and once reached the plan pays covered expenses in full for the remainder. Charges above the usual, reasonable, and customary limit may still be billed and often fall outside it. Charges above customary limits often fall outside. The plan then meets covered expenses in full.

52. B — A PPO is a network of providers offering discounted rates, with no primary care gatekeeper, so specialists may be seen directly and out-of-network care remains covered at a reduced benefit level. HMO and point of service models require referral. Gatekeeping is the sharpest distinction between models. Out-of-network care remains covered at reduced benefit.

53. D — Utilization review examines whether care is necessary and appropriately delivered. Precertification applies before treatment, concurrent review during a hospital stay, and retrospective review afterward. Failing to obtain required precertification ordinarily produces a reduced benefit instead. Each review type applies at a different stage. Precertification comes before and retrospective review afterward.

54. A — A health reimbursement arrangement is funded solely by the employer, and employees may not contribute. Reimbursements for qualified medical expenses are not taxable income to the employee, but because the employer funds and owns it, nothing travels with the worker. Reimbursements remain untaxed to the employee throughout. Employer ownership explains why nothing travels onward.

55. C — Respite care provides temporary relief to an unpaid family caregiver, covering short periods of substitute care so the caregiver can rest. It is distinct from skilled nursing, adult day care, and continuing home health care in every respect. Short substitute stays are what it funds. Skilled nursing serves an entirely different purpose.

56. B — A Part A benefit period ends after sixty consecutive days out of a hospital or skilled nursing facility, so a later readmission begins a fresh period with a new deductible. A beneficiary may pay several deductibles within one calendar year. Several deductibles in one year are possible. Sixty consecutive days out of facility resets it.

57. A — After the annual deductible, Part B pays eighty percent of the approved amount and the beneficiary is responsible for the remaining twenty percent, with no out-of-pocket maximum limiting the total. That exposure is the largest gap a supplement fills. That gap is what a supplement fills. No out-of-pocket maximum limits that twenty percent.

58. D — End-stage renal disease and amyotrophic lateral sclerosis both bypass the twenty-four month waiting period that otherwise follows entitlement to Social Security disability benefits. No other diagnosis carries that exception, and both progress too quickly to wait. Both conditions progress too fast for waiting. No other diagnosis carries a comparable exception.

59. D — Medicaid is needs-based, so eligibility turns on income and countable resources measured against thresholds set by each state within federal requirements. Medicare is an entitlement earned through work credits and administered federally on uniform terms nationwide. Thresholds differ from state to state accordingly. Medicare is earned through credits and administered federally.

60. B — The birthday rule looks only at which parent's birthday falls earlier in the calendar year, and the year of birth is irrelevant, so January precedes July. A court order governs instead where the parents are separated or divorced. Court orders displace the rule after divorce. Year of birth is irrelevant to the rule.

61. C — Under nonduplication the secondary plan pays only the excess, if any, of what it would have paid alone over what the primary actually paid. Where the primary paid as much or more, nothing remains and the secondary pays nothing. Standard coordination would treat the member more generously. Standard coordination would leave her considerably better off.

62. A — Non-occupational coverage excludes what workers compensation would cover, so an insured injured at work collects from that system and nothing from the private policy. Occupational or twenty-four-hour coverage protects the insured in both settings instead. Compensation systems cover the workplace injury instead. Twenty-four-hour coverage would protect her in both. Location of injury decides it.

63. A — Workers compensation provides medical care, income replacement, rehabilitation, and death benefits without regard to fault, and in exchange the employee surrenders the right to sue the employer in tort. A Texas non-subscriber forfeits exactly that. Certainty of payment is bought with tort rights. A Texas non-subscriber forfeits exactly that protection.

64. B — Subrogation allows an insurer that has paid a claim to step into the insured's position and pursue the party responsible, placing the cost on the party at fault rather than on the premium-paying pool. It prevents recovery beyond actual loss. Insurance indemnifies loss without producing any gain. Cost falls on the wrongdoer rather than the pool.

65. C — Field underwriting means observing what the application cannot capture and communicating it to the insurer through the agent's report, which is not part of the entire contract and is not shown to the applicant. It informs underwriting rather than deciding. Observations reach the insurer without reaching the applicant. The agent's report is outside the entire contract.

66. D — A corrected answer requires the applicant's initials, because the document must reflect what the applicant actually approved. An agent who alters an answer without initials has created a record the applicant never authorized, undermining the insurer at claim. Unauthorized alterations weaken the insurer at claim. The record must reflect what the applicant approved.

67. B — A conditional receipt attaches coverage from the later of the application date or any required medical examination, but only where the applicant proves insurable as a standard risk. A binding receipt would attach coverage unconditionally instead. A declined applicant never had coverage at all. A binding receipt attaches coverage unconditionally instead.

68. C — Third-party premium funding, a face amount unrelated to demonstrated need, an applicant with no independent reason for coverage, and planned early ownership transfer are the recognized warning signs. An agent submitting anyway becomes a participant in it. Insurable interest is manufactured rather than genuine. Warning signs cluster together rather than singly.

69. D — The MIB holds coded records of conditions previously reported by member insurers and signals where an underwriter should investigate further. It reports codes rather than underwriting decisions, and an insurer may not decline solely on such a code. Further enquiry rather than decision is its function. Coded findings direct enquiry rather than deciding.

70. A — The Fair Credit Reporting Act requires written notice that a consumer report may be obtained and entitles the applicant to learn the nature and scope of an investigative report on request. Disputing wrong information is what the Act protects. Applicants may then dispute inaccurate information. Notice of the reporting agency follows any decline.

71. C — Premium funds are received in a fiduciary capacity, must be kept separate from the agent's own money, and must be transmitted promptly. Commingling is the mixing itself and is prohibited regardless of outcome, because mixed funds cannot be traced. Separation of funds is the fiduciary obligation. Prompt transmission to the insurer is required.

72. D — An illustration is the insurer's own representation of its product, and an agent may not alter, annotate, or produce an unauthorized version even to make the figures more conservative. Doing so makes the agent the author of an unapproved projection. Only the insurer may author its own projections. Unauthorized figures make the agent their author.

73. A — Twisting is inducing replacement through misrepresentation or an incomplete comparison, and showing only a premium saving while omitting the restarted contestable period, restarted suicide clause, and current-age pricing is exactly that omission. Disadvantages omitted make the comparison incomplete. Restarted clocks and current-age pricing go unmentioned. A client's stated priorities never narrow that duty.

74. B — Churning generates replacement business for the commission with no benefit to the client, often within the same insurer's book. Twisting instead induces replacement through misrepresentation or an incomplete comparison, and both are separately prohibited. Commission without client benefit defines the practice. Twisting instead turns on misrepresentation entirely. Client benefit is the dividing line.

75. B — Rebating is offering any valuable consideration not specified in the policy as an inducement to purchase, and it remains prohibited even where the client asks. In most circumstances both the agent offering and the client accepting are in violation. Client agreement never legitimizes the inducement. Both the offering agent and accepting client offend.

76. A — At least twelve of the twenty-four hours must be classroom or classroom-equivalent, which caps self-study at the remaining twelve. Seven classroom hours falls five short of that minimum regardless of the total, and three hours must separately be ethics. Ethics hours sit inside the total, never above. Self-study is capped at the remaining twelve hours.

77. C — Between ninety days and one year after expiration a license cannot be renewed but may be reinstated without retaking the examination, by filing a new application with the license fee plus an additional fee. Within ninety days late renewal applies. One year marks the outer boundary entirely. Within ninety days simple late renewal remains available.

78. D — The sponsored applicant must complete forty hours of training provided by the appointing company or agency within thirty days of the license application. The temporary license runs one hundred eighty days and cannot be renewed at all. One hundred eighty days limits the temporary license. The temporary license cannot be renewed once expired.

79. A — The license application must be filed within twelve months of passing, or the examination has to be taken again from the beginning. Twenty-one months exceeds that window, so the earlier result no longer supports an application at all. The examination result simply expires after twelve months. Filing within twelve months of passing is required.

80. D — Classification turns on where the insurer was organized. Alien means organized under the law of another country, foreign under the law of another state, and domestic under Texas law. A company from another American state would be foreign. Country rather than state of organization decides. A company from another American state would be foreign.

81. B — An appointment is separate from a license. The insurer files notice of appointment with the Department, and only then may the agent sell for that insurer, so selling without one on file violates the

Code regardless of the license held. The filing precedes any selling for that company. Each additional company appointment carries its own fee.

82. C — Net cash surrender or withdrawal value is limited to one hundred thousand dollars per individual life, aggregating all policies with that insurer. Death benefits are covered to three hundred thousand and annuity present value to two hundred fifty thousand. Aggregation across policies precedes applying the cap. Limits apply per individual life rather than per policy.

83. A — Using the existence of the Association to induce a purchase is prohibited in any form. Presenting it as a safety net encourages consumers to disregard an insurer's financial strength, which is exactly the judgment the market depends on them exercising. The association is never a selling point. Financial strength is what consumers must weigh.

84. C — Texas requires a grace period of at least one month for every premium after the first, and where expressed in days rather than as a month, at least thirty-one days must be granted. The policy remains in full force throughout. One month is the alternative statutory formulation. The policy remains in full force throughout that time.

85. B — A Texas life policy becomes incontestable after two years from its date during the insured's lifetime, so at sixteen months it remains contestable for material misstatements. Nonpayment of premium is separately excepted from that protection throughout. Two years from the policy date is the boundary. Nonpayment of premium is separately excepted always.

86. D — Texas requires loans to be made available after premiums for three full years have been paid and a cash value is available, so a request at twenty-nine months falls short. Term life and pure endowment policies are exempt entirely. Cash value alone creates no borrowing right. Term and pure endowment contracts remain exempt entirely.

87. C — Misstatement of age is a proportionality remedy applied whether the age was understated or overstated. The amount payable is adjusted to what the premium actually paid would have purchased at the correct age, with no fraud needing proof. Understated age produces the identical adjustment. No fraud need be proved for that adjustment.

88. D — The governing standard judges an advertisement by the overall impression it creates rather than by whether each statement is literally accurate. Arrangement, emphasis, and omission can mislead a reasonable consumer, and a buried disclaimer cures nothing. Emphasis and omission can mislead by themselves. A buried disclaimer does not cure a misleading whole.

89. B — Where the Buyer's Guide and required disclosure document were not provided at or before application, a free look of at least fifteen calendar days must be given, disclosed prominently on the cover page and running from receipt. The notice appears on the contract's cover page. Timely delivery of both documents avoids it altogether.

90. A — Replacement reaches coverage that is terminated, lapsed, surrendered, reduced in value, or converted to paid-up or extended term in connection with a new purchase. A reduction in face amount is

caught squarely by that definition. Value reduced in connection with a purchase counts. Conversion to extended term is caught identically.

91. D — The replacing insurer must notify the existing insurer that replacement is proposed, giving that company an opportunity to communicate with its own policyholder and present its own comparison. The applicant then weighs both positions together. Conservation gives the existing insurer its say. The applicant then decides with both positions before her.

92. B — The Standard Nonforfeiture Law prescribes minimum values and requires a table of guaranteed values showing benefits available at the end of a series of years. That printed table makes the guarantee enforceable rather than merely theoretical. The schedule binds the insurer as a floor. More generous values may always be provided instead.

93. A — A departing group member may convert to an individual policy without evidence of insurability within a stated period after coverage terminates, and the converted policy is issued at attained age. The right is most valuable to someone now uninsurable. Evidence of insurability is never required here. The conversion window closes and does not reopen.

94. C — Credit life pays the creditor the balance of the debt if the debtor dies, so the amount of insurance may not exceed the indebtedness and coverage decreases as the loan amortizes. It may not be made a condition of lending. Coverage decreases as the loan amortizes downward. Credit insurance may not be made a condition of lending.

95. C — Coverage attaches from the moment of birth and does not depend on prior enrollment, so a baby born needing immediate care is covered while paperwork is still being completed. Notification and additional premium sustain coverage beyond that period. Prior enrollment is never a condition of cover. Notification and premium sustain coverage beyond that period.

96. A — A Medicare supplement policy may not be canceled or non-renewed on the ground of health status, claims experience, or age. Nonpayment of premium and material misrepresentation remain legitimate grounds, and that restriction makes the coverage dependable. Nonpayment and misrepresentation remain the valid grounds. Guaranteed renewability is the practical value purchased.

97. B — HIV testing requires separate written informed consent on a form meeting the applicable rule, and the general medical authorization signed with the application does not satisfy it. Results are confidential and orientation may never be used in underwriting. Confidentiality restricts who may see the results. General medical authorizations never satisfy that requirement.

98. D — Thirty-three employees falls inside the Texas small employer band of two to fifty, so guaranteed issue applies and the carrier must issue any plan it offers regardless of health status or claims history. Refusal by price is equally unavailable. Rating is constrained as tightly as refusal. Two to fifty employees defines the Texas band.

99. C — Guaranteed issue does not mean issue on any terms. A carrier may impose minimum participation and minimum employer contribution requirements and may decline an employer failing

them, because both prevent adverse selection in that market. Adverse selection is what those rules prevent. The decline must rest on the arrangement, never on health.

100. D — Required preventive services must be covered without cost sharing when delivered by a network provider, which is why a routine screening ordinarily produces no bill. A diagnostic test investigating an existing symptom is treated quite differently. Purpose of the test rather than its type decides. A diagnostic test investigating a symptom differs entirely.

101. A — The continuing education total does not increase when a licensee holds more than one license type; twenty-four hours satisfies the requirement across all licenses held. Three of those hours must be ethics and at least twelve classroom or classroom-equivalent. Three ethics hours sit inside that same total. Multiple licenses do not multiply the burden at all.

102. B — A licensee short of the requirement is fined for each deficient hour, subject to a maximum per license, and must complete the hours before renewal. Failing to complete them, pay the fine, and renew within ninety days of expiration cancels the license. Ninety days is the boundary for late renewal.

103. D — A change of address must be reported to the Department in writing within thirty days, and telling an appointing insurer does not satisfy that separate obligation. Felony convictions and administrative action elsewhere must also be reported in their own periods. Failing to report is itself a disciplinary ground. Insurer notification never substitutes for Departmental notice.

104. B — The Commissioner enforces the Insurance Code and adopts rules implementing it, and may examine records, investigate, hold hearings, impose penalties, and issue cease and desist orders. Enacting, amending, and repealing statutes belong to the Legislature alone. Rules implement statutes rather than creating them. Enacting, amending, and repealing all belong to the Legislature.

105. A — Commissions may be paid to and shared only with persons licensed at the time of the transaction, which closes the obvious route around the licensing requirement. Neither client consent, a small amount, nor the absence of selling makes it lawful. Licensing cannot be circumvented by paying intermediaries. No client consent alters that licensing restriction whatever.

106. C — Unfair discrimination forbids different rates, terms, or benefits between insureds of the same class and essentially the same hazard. Charging different premiums for genuinely different risks is lawful underwriting, so the violation lies in treating equivalents differently. Genuine risk differences remain a lawful basis. Same class and same hazard is the operative test throughout.

107. A — Annuity benefits are covered to two hundred fifty thousand dollars in present value per individual life. Death benefits are limited to three hundred thousand, net cash surrender value to one hundred thousand, and basic hospital and major medical to five hundred thousand. Each coverage category carries its own separate statutory ceiling amount.

108. B — Basic hospital, medical-surgical, and major medical coverage carries a five hundred thousand dollar limit per individual, the highest of the categories. Long-term disability and long-term care are limited to three hundred thousand, and other supplemental health to two hundred thousand. Each category carries its own statutory ceiling. Knowing which tier applies decides these questions reliably.

109. C — Using the existence of the Association to induce a purchase is prohibited in any form. Presenting it as a safety net encourages consumers to disregard an insurer's financial strength, which is exactly the judgment the market depends on them exercising. Solvency judgment belongs with the buyer instead. Financial strength is precisely what buyers must weigh themselves.

110. D — The policy may provide for an interest charge on the unpaid premium during the grace period, and where it does the rate must be specified in the contract. The policy may also stipulate deduction of an overdue premium at death. Overdue premium may also be deducted at death. Specification of the rate is the governing condition throughout.

111. B — A Texas life policy becomes incontestable after two years from its date during the insured's lifetime, so at eight months it remains contestable for material misstatements in the application. Nonpayment of premium is separately excepted from that protection throughout. Two years from the policy date is the boundary. Nonpayment of premium is excepted at any time.

112. D — Term life and pure endowment policies are not required to provide loans even where they happen to generate cash values, because the requirement attaches to the type of policy rather than the presence of value. Permanent forms must offer loans. Value alone creates no borrowing entitlement here. Permanent forms carry the obligation after three full years.

113. A — The Buyer's Guide explains life insurance in general terms while the policy summary sets out the specific contract's premiums, benefits, and values. Both are delivery requirements attached to the sale, allowing comparison on a genuinely common basis. One explains the product, the other the contract. Both documents are delivery requirements rather than marketing.

114. C — Illustrations must clearly distinguish guaranteed from non-guaranteed elements, and presenting a projection as though it were guaranteed is a misrepresentation whatever the footnotes state. A signed acknowledgment does not cure a statement misleading at sale. A signed receipt cannot repair a misleading statement. Guaranteed and non-guaranteed columns must be distinguished clearly on the face.

115. B — The replacing agent determines whether replacement is involved by asking the applicant, presents the required notice, obtains signatures, submits a statement identifying the coverage replaced, and provides copies of sales material used. The existing insurer's consent is never required. Copies of any sales material go in too. Documentation makes the recommendation reviewable long afterward.

116. D — The Standard Nonforfeiture Law prescribes minimum values and requires a table of guaranteed values showing benefits available at the end of a series of years. An insurer may provide more generous values but may never fall below that printed schedule. The printed schedule binds the insurer as a floor. The schedule operates as a floor rather than a fixed sum.

117. C — A departing group member may convert to an individual policy without evidence of insurability within a stated period after coverage terminates, and the converted policy is issued at attained age. The right is most valuable to someone now uninsurable. Attained age pricing reflects her current age. The conversion window closes and does not reopen.

118. A — Credit insurance may not lawfully be made a condition of obtaining the loan, because the creditor controls the transaction and the risk of pressure on the borrower is real. Naming the creditor as beneficiary remains an entirely normal feature. Capping the sum at the debt remains normal. Creditor control over the transaction explains the rule.

119. B — A child past the limiting age may remain covered where incapable of self-sustaining employment because of intellectual or physical disability and dependent for support. The plan may require proof of incapacity and dependency, but not more frequently than annually. Incapacity and dependency are the elements proved. Annual verification is the maximum frequency permitted.

120. D — Texas mandates coverage for the necessary care and treatment of chemical dependency, because the condition was historically excluded or covered far more narrowly than others and because untreated dependency reliably generates medical costs elsewhere in the plan. Untreated dependency generates costs elsewhere anyway. Historic exclusion is what prompted the mandate originally.

121. A — An insurer may not use sexual orientation in underwriting and may not use marital status, occupation, living arrangements, or similar proxies to infer it. Underwriting must rest on documented medical evidence rather than inference about a person's life. Occupation and marital status are equally impermissible. Medical evidence alone may properly support a decline.

122. C — The Texas small employer framework has long operated on a band of two to fifty eligible employees, so seventy-four sits outside it. Employers above the band are large employers and fall outside the small employer protections, including guaranteed issue. The band runs from two to fifty employees. Larger employers negotiate on ordinary commercial terms.

123. D — A carrier ceasing to write small employer coverage must give advance notice to the Commissioner and to every affected employer, and is ordinarily barred from re-entering the market for a period of years. Together these prevent opportunistic exit. Opportunistic exit and swift return are both prevented. Affected employers receive notice alongside the Commissioner.

124. B — The premium tax credit reduces the monthly cost of a Marketplace plan for eligible households and may be taken in advance against premiums or claimed at filing. Cost-sharing reductions separately lower deductibles with a designated tier plan. The two supports carry different eligibility rules. Advance payment or claiming at filing are both available.

125. A — Non-grandfathered individual and small group plans must cover essential health benefits across defined categories, and the outline draws attention to mental health and substance use disorder services, pediatric services, and preventive services. Adult dental falls outside. Adult dental and cosmetic work fall outside. Those three are the categories the outline names.

126. C — Applicable large employers must report on the coverage they offer and may face payments where they do not offer coverage meeting the required standard. All employers must notify employees of the Marketplace, whatever their eventual size. Marketplace notification binds every employer regardless. Employees must be told of the Marketplace regardless of size.

127. B — An HMO issues an evidence of coverage setting out the services an enrollee is entitled to, the conditions attached, and the enrollee's rights, and it must be approved by the Department before use. Insurers issue policies instead of these. Group insurers issue certificates under master contracts. Departmental approval precedes any use of the document.

128. A — Health status, the volume of covered services used, and complaints filed with the Department are never permissible grounds for nonrenewal by a Texas health maintenance organization. Nonpayment of premium, fraud, and permanent relocation beyond the service area all remain legitimate. Nonpayment and fraud remain legitimate grounds available. Relocation and misrepresentation remain legitimate grounds instead.

129. D — Emergency care must be covered without regard to network status, because an enrollee facing an emergency has no meaningful opportunity to select a participating provider. Texas also addresses billing where an out-of-network provider treats at a network facility. Absence of genuine choice triggers the protection. Absence of genuine choice is what triggers protection.

130. C — Misappropriating or converting money received in the insurance business is a listed ground for denial, suspension, or revocation. Even brief personal use of premium money is conversion, and repaying it afterward does not undo the violation committed. Restitution does not undo the conversion itself. Even a single day's personal use is conversion.