

PRACTICE EXAM 4: 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. An owner of an ordinary whole life policy stops paying premiums in year fifteen and elects reduced paid-up. The result is:

- A. the same face amount for a limited number of years
- B. a cash payment ending all insurance protection
- C. term coverage renewable to the maturity age
- D. a smaller permanent policy with no further premium

2. Compared with paying annually, paying the same whole life premium monthly results in:

- A. a lower total annual outlay for the policyowner
- B. a higher total annual outlay for the policyowner
- C. an identical total outlay across the policy year
- D. a proportionate reduction in the death benefit

3. A whole life policy is described as participating. This means the policy:

- A. permits the owner to direct separate account investments
- B. allows the owner to skip premiums in any policy year
- C. is eligible to receive dividends when they are declared

D. guarantees a minimum interest rate on accumulated value

4. An applicant wants coverage that will never require another premium after fifteen years but must remain in force for life. The fit is:

- A. a fifteen year level term policy, renewable at expiry
- B. a fifteen-pay whole life policy, paid up at that point
- C. an ordinary whole life policy paid to maturity age
- D. a universal life policy funded at the target premium

5. The principal risk to an owner who funds a universal life policy at the minimum level is that:

- A. the insurer may unilaterally reduce the face amount
- B. the policy automatically becomes a Modified Endowment Contract
- C. the guaranteed interest rate falls below the stated minimum
- D. account value may be exhausted and the policy may lapse

6. Which death benefit option produces a higher cost of insurance charge in a universal life policy?

- A. Option B, paying face amount plus cash value
- B. Option A, paying a level face amount only
- C. Both charge identically regardless of option
- D. Neither, since cost of insurance is fixed at issue

7. An insured holds convertible term and develops a serious illness in year six. Exercising the conversion privilege:

- A. requires a new medical examination before approval
- B. is permitted only where health has not deteriorated
- C. forfeits all premiums paid under the term policy
- D. requires no new evidence of insurability at all

8. A policy insuring two lives and terminating on the first death is:

- A. survivorship life, funding estate settlement costs
- B. joint life, priced against the poorer of two risks
- C. a family policy covering all household members
- D. a second-to-die contract with relaxed underwriting

9. Which statement about term insurance cash value is correct?

- A. Term builds none, so nonforfeiture options do not arise
- B. Term builds cash value more slowly than whole life
- C. Term builds cash value only after ten policy years
- D. Term builds cash value equal to premiums paid in

10. Under an indexed life policy, the insurer holds the funds supporting cash value in:

- A. a separate account tracking the chosen index
- B. a trust administered for the policyowner's benefit
- C. its general account, using the index as a measure
- D. an escrow account maintained under state supervision

11. A policy summary delivered to a prospect differs from a Buyer's Guide because the summary:

- A. explains how life insurance operates in general terms
- B. states this policy's premiums, benefits, and values
- C. discloses the agent's commission on the transaction
- D. reports the insurer's most recent financial results

12. The insuring clause of a life policy sets out:

- A. the premium amount and the frequency required
- B. the exclusions limiting the insurer's liability
- C. the insurer's promise to pay on due proof of death
- D. the parties competent to form the contract

13. A beneficiary designation naming my children without listing names is:

- A. invalid, because beneficiaries must be identified
- B. valid only where all children are already adults
- C. treated as naming the eldest child exclusively
- D. a class designation, avoiding amendment as families change

14. If no named beneficiary survives the insured, policy proceeds are payable to:

- A. the insured's estate, exposing them to probate
- B. the policyowner's nearest surviving relative
- C. the insurer, which retains the accumulated value
- D. a state fund administering unclaimed benefits

15. The grace period provision protects an insured who:

- A. pays a premium late but within the stated period
- B. misstates their age on the original application
- C. changes to a more hazardous occupation mid-term
- D. cancels the policy shortly after it is delivered

16. Which is true of an accidental death benefit rider?

- A. It pays whenever death occurs during the policy term

- B. It pays only where death results from accident
- C. It doubles the benefit for death from any cause
- D. It converts to permanent coverage on the insured's request

17. A collateral assignment of a life policy ends when:

- A. the insured reaches the policy's maturity age
- B. the assignee provides written notice to the insurer
- C. the underlying debt has been fully satisfied
- D. the policyowner names a new primary beneficiary

18. An insured commits suicide thirty months after the policy was issued. The insurer:

- A. refunds premiums and pays no death benefit
- B. pays the accumulated cash value only
- C. denies the claim as an excluded cause of death
- D. pays the full death benefit as with any other death

19. A guaranteed insurability rider permits additional coverage to be purchased:

- A. at any time the policyowner chooses to apply
- B. at specified future dates or stated life events
- C. only where the insured remains in preferred health
- D. only during the policy's first two contract years

20. An accelerated death benefit may affect the insured's:

- A. eligibility for certain public assistance benefits
- B. right to name a contingent beneficiary later
- C. ability to reinstate the policy after a lapse
- D. classification as a standard underwriting risk

21. The waiting period under a waiver of premium rider begins when:

- A. the policy is delivered to the policyowner
- B. the insurer approves the disability claim
- C. the qualifying total disability commences
- D. the first unpaid premium becomes overdue

22. An insurer discovers at claim that the insured's age was understated by four years. The insurer will:

- A. void the policy and return all premiums received
- B. pay the full face amount and bill the shortfall
- C. deny the claim for material misrepresentation
- D. pay what the premium paid would have purchased

23. Which is NOT a required element of a valid insurance contract?

- A. Offer and acceptance between the parties
- B. Consideration given by each of the parties
- C. Written approval from the state insurance regulator
- D. A legal purpose consistent with public policy

24. An insurer's competence to contract is evidenced by:

- A. holding a valid certificate of authority in the state
- B. maintaining reserves exceeding statutory minimums
- C. appointing at least one resident licensed agent
- D. filing its policy forms with the national association

25. Because an insurance policy is a contract of adhesion, any genuine ambiguity is construed:

- A. in favor of the party who drafted the wording
- B. according to industry custom and prior practice
- C. by reference to the agent's oral explanation
- D. against the insurer and in favor of the insured

26. An insurance contract is unilateral because:

- A. only one party receives value under the agreement
- B. only the insurer makes a legally enforceable promise
- C. only one insured may be covered under the contract
- D. only the applicant may terminate the arrangement

27. An applicant states height and weight inaccurately by a trivial margin. This is:

- A. a warranty breach permitting immediate rescission
- B. an immaterial misrepresentation with no contractual effect
- C. concealment of a fact known to the applicant
- D. fraud, permitting the insurer to deny any claim

28. An agent's express authority is found in:

- A. the reasonable expectations of the buying public
- B. acts customarily performed by agents generally
- C. the policy issued to the individual applicant
- D. the agency contract between agent and insurer

29. Which annuity payout option exhausts the fund over a chosen number of years without regard to survival?

- A. Life with ten year period certain payments
- B. Joint and survivor at a reduced percentage
- C. Period certain, paying for a fixed term
- D. Installment refund guaranteeing the purchase price

30. An annuity owner and annuitant may be different persons because the owner:

- A. holds the contract rights while the annuitant measures payments
- B. must always be a corporation rather than an individual
- C. receives the payments while the annuitant pays premiums
- D. is required by law to be older than the annuitant

31. Surrender charges on a deferred annuity typically:

- A. apply for the entire life of the contract
- B. increase steadily across the surrender period
- C. decline over a schedule and eventually disappear
- D. apply only to amounts withdrawn after annuitization

32. A fixed annuity places the investment risk on:

- A. the insurer, which guarantees a minimum rate
- B. the owner, who directs subaccount allocations
- C. the annuitant, who bears longevity risk alone
- D. the beneficiary, who receives residual amounts

33. Which retirement arrangement covers owner-employees of unincorporated businesses?

- A. A section 401(k) salary deferral arrangement
- B. A section 403(b) tax-sheltered annuity plan
- C. A section 457 deferred compensation plan

D. A Keogh plan, sometimes called HR-10

34. A qualified plan must satisfy federal requirements including:

- A. guaranteed minimum investment returns to participants
- B. nondiscrimination in favor of highly compensated employees
- C. employer contributions equal for every participant
- D. immediate vesting of all employer contributions

35. A nonqualified annuity owner has basis in the contract because:

- A. the insurer credits a guaranteed minimum rate
- B. the contract was purchased before annuitization
- C. contributions were made with after-tax dollars
- D. the owner has already reached retirement age

36. Which best describes the taxation of employer-paid group life coverage to the employee?

- A. Cost above a statutory threshold is imputed income
- B. The full cost of coverage is imputed income annually
- C. No portion is ever treated as income to the employee
- D. The death benefit becomes taxable to the beneficiary

37. An owner takes a withdrawal from a deferred annuity before annuitizing. Tax applies:

- A. to nothing, since the contract remains in force
- B. proportionally under the exclusion ratio formula
- C. to the basis portion first, then to any gain
- D. to the gain portion first, until it is exhausted

38. A worker dies leaving a spouse caring for a six year old child. Social Security survivor benefits to that spouse will:

- A. continue until the child reaches the qualifying age
- B. continue until the spouse remarries or reaches sixty
- C. be payable only if the worker was currently insured
- D. continue uninterrupted until the spouse retires

39. Business overhead expense premiums are deductible, which means the benefits are:

- A. received free of income tax by the business
- B. taxable to the business when received
- C. taxable only where they exceed actual expenses
- D. treated as a return of capital to the owner

40. Which best describes a Modified Endowment Contract's death benefit?

- A. Taxable as ordinary income to the beneficiary
- B. Reduced by any penalty applied during the insured's life
- C. Generally received income-tax-free by the beneficiary
- D. Limited to the total premiums paid into the contract

41. An insurer reviewing an application orders a paramedical examination. This is ordinarily triggered by:

- A. any adverse entry appearing on the MIB report
- B. the applicant's age combined with the face amount
- C. the applicant's request for preferred rate classification
- D. the agent recommending it in the agent's report

42. An applicant is issued a policy with an exclusion rider naming a specific condition. This outcome is:

- A. a decline, because coverage for that condition is refused
- B. a preferred classification with a limitation attached
- C. unlawful, because exclusions must apply to all insureds
- D. an alternative to declining the applicant outright

43. At delivery, an agent asks the insured to confirm nothing has changed medically. Why?

- A. start the free look period from a documented date
- B. confirm the beneficiary designation remains accurate
- C. acknowledge that the policy was actually delivered
- D. confirm health has not changed since the application

44. An applicant who reasonably relies on an agent's apparent authority is protected because:

- A. agents are personally liable for their representations
- B. the insurer permitted the appearance to persist
- C. state law makes all agents general agents by default
- D. the entire contract provision extends to oral statements

45. Which underwriting source specifically addresses an applicant's finances, occupation, and lifestyle?

- A. An inspection or consumer report from an agency
- B. An attending physician statement from the doctor
- C. A paramedical examination arranged by the insurer
- D. The MIB report exchanged among member insurers

46. An agent who suspects an application involves a stranger-originated arrangement should:

- A. submit it and allow underwriting to decide the matter

- B. submit it with a note requesting expedited review
- C. decline to submit business bearing those warning signs
- D. require the investor to sign a disclosure statement

47. Two waiting periods in one disability contract do different jobs. Which describes the earlier one?

- A. applies to each successive claim the insured files
- B. delays payment after every disability has begun
- C. runs from the policy date and bars sickness only
- D. caps the total duration of benefits payable

48. Which definition of disability measures loss of earnings rather than ability to perform duties?

- A. Own occupation, applied for an initial period
- B. Any occupation, applied after that period ends
- C. Presumptive disability, on catastrophic loss
- D. Income replacement, proportionate to earnings lost

49. Disability income insurance typically replaces what portion of earned income?

- A. the full amount of pre-disability earned income
- B. roughly sixty to seventy percent of earned income
- C. a flat statutory amount set by state regulation
- D. an amount equal to Social Security disability benefits

50. An accidental death and dismemberment policy pays nothing for:

- A. death resulting from a sudden cardiac event
- B. loss of sight in both eyes following a collision
- C. severance of one hand in a workplace accident
- D. accidental death occurring within the stated period

51. A basic surgical expense policy pays according to:

- A. a schedule assigning an amount to each procedure
- B. the usual and customary charge in the local area
- C. a percentage of the surgeon's actual billed charge
- D. the member's remaining annual deductible balance

52. Covered charges reach \$4,500. With a \$500 deductible and eighty percent plan coinsurance, what is owed by the member?

- A. \$500, being the annual deductible amount only
- B. \$900, being twenty percent of the total charges
- C. \$1,300, being the deductible plus coinsurance
- D. \$800, being twenty percent after the deductible

53. A health reimbursement arrangement may be funded by:

- A. the employee, through pre-tax salary reduction
- B. the employer alone, with no employee contribution
- C. either party, in any proportion they agree
- D. the employee, using after-tax personal funds

54. Which feature is unique to the health savings account among consumer-directed arrangements?

- A. Reimbursement of qualified medical expenses tax-free
- B. Employer funding permitted under the arrangement
- C. Availability through an employer benefit program
- D. Portability combined with indefinite balance rollover

55. A gatekeeper in a managed care plan is responsible for:

- A. approving payment of submitted claims
- B. negotiating discounted provider contracts
- C. determining the member's monthly premium
- D. coordinating care and making specialist referrals

56. An HMO member seeking non-emergency care outside the network will ordinarily find that care:

- A. is not covered at all by the plan
- B. is covered at the full in-network benefit
- C. is covered at a reduced benefit level
- D. is covered after a separate deductible applies

57. Long-term care benefits paid under a tax-qualified policy are generally:

- A. taxable as ordinary income when received
- B. taxable only on amounts exceeding actual costs
- C. received free of federal income tax
- D. taxable where premiums were deducted as medical expense

58. The ninety-day requirement in a tax-qualified long-term care policy refers to:

- A. the waiting period before benefits begin
- B. the expected duration of the impairment
- C. the maximum period benefits will be paid
- D. the notice period for canceling the policy

59. A Partnership long-term care program allows a policyholder who exhausts benefits to:

- A. purchase replacement coverage without underwriting
- B. receive an extension of benefits funded by the state
- C. protect assets equal to benefits paid when seeking Medicaid
- D. recover premiums paid over the life of the policy

60. COBRA applies to employers with:

- A. ten or more employees on a typical business day
- B. twenty or more employees on a typical business day
- C. fifty or more employees on a typical business day
- D. any number of employees offering group coverage

61. A short-term medical policy is best described as:

- A. temporary underwritten coverage bridging a gap
- B. guaranteed issue coverage with no exclusions
- C. a permanent alternative to major medical
- D. a fixed indemnity paying per day of confinement

62. A vision plan differs from a dental plan principally because vision benefits are:

- A. tiered by preventive, basic, and major services
- B. subject to a lifetime rather than annual maximum
- C. paid as a percentage of the provider's charge
- D. allowance-based, with the member paying any excess

63. Worksite or voluntary coverage offered through an employer is:

- A. funded by the employer as a fringe benefit
- B. paid entirely by the employee, usually by payroll deduction
- C. available only to employees with five years of service

D. required to be offered to all employees equally by law

64. The reinstatement provision in a health policy provides that where the insurer requires an application and issues a conditional receipt, the policy is reinstated:

- A. on approval, or automatically after a stated number of days
- B. immediately upon the insurer accepting the late premium
- C. only after a new medical examination has been completed
- D. at the start of the next policy year following approval

65. An insured injured on holiday cannot reach anyone for a month. Notice of claim rules provide that notice be given:

- A. the claim is barred entirely from consideration
- B. the benefit payable is reduced by a stated percentage
- C. the insured must submit an affidavit explaining delay
- D. as soon thereafter as is reasonably possible

66. Which provision addresses benefits payable where the insured holds coverage with the same insurer under more than one policy?

- A. Relation of earnings to insurance, reducing benefits
- B. Change of occupation, adjusting the benefit level
- C. Other insurance in this insurer, an optional provision
- D. Physical examination and autopsy, permitting review

67. An insurer may require an autopsy under a health policy:

- A. in all cases involving the death of an insured
- B. only where the beneficiary consents in writing
- C. where not forbidden by law, at the insurer's expense

D. only where the death occurred outside a hospital

68. An insured moves to a more hazardous occupation without notifying the insurer and then files a claim. The insurer will:

- A. deny the claim entirely for failure to notify
- B. pay what the premium would have purchased at the higher rate
- C. pay in full and bill the additional premium owed
- D. void the policy from the date the occupation changed

69. Under a guaranteed renewable classification, the insurer may increase premiums:

- A. for any individual insured whose claims are heavy
- B. only with the written consent of the insured
- C. only at five year intervals set out in the contract
- D. for an entire class of policyholders, never one insured

70. A social insurance supplement rider pays benefits that:

- A. reduce if Social Security disability is awarded
- B. increase automatically when Social Security begins
- C. continue unchanged regardless of any public award
- D. replace Social Security benefits for the first two years

71. A member fails to obtain required pre-authorization for elective surgery that is otherwise covered. The likely outcome is:

- A. payment at a reduced benefit as a penalty
- B. outright denial of the entire claim
- C. cancellation of the member's coverage
- D. payment in full, since the care was covered

72. Which product may still refuse to pay for a condition the insured had before buying it?

- A. an individual major medical plan bought through the Marketplace
- B. a hospital indemnity policy sold as an excepted benefit
- C. a small group comprehensive medical plan renewed annually
- D. a large employer group major medical plan offered to staff

73. A specified disease policy and a critical illness policy differ principally because critical illness coverage:

- A. pays only after a hospital confinement occurs
- B. reimburses expenses rather than paying a sum
- C. names several conditions and pays a lump sum
- D. requires the insured to stop working entirely

74. Medicare Part A covers hospital days sixty-one through ninety in a benefit period:

- A. in full, with no beneficiary cost sharing
- B. not at all, requiring lifetime reserve days
- C. at fifty percent of the approved amount
- D. subject to a daily coinsurance amount

75. Medicare Part B covers which service?

- A. Inpatient hospital room and board charges
- B. Long-term custodial nursing home care
- C. Outpatient prescription drugs at the pharmacy
- D. Durable medical equipment and outpatient care

76. A Medigap policy may be issued without regard to health during:

- A. any period the beneficiary is enrolled in Part A
- B. the annual Medicare Advantage election window
- C. the six month open enrollment period
- D. the first five years after reaching age sixty-five

77. Under the birthday rule, if one parent was born in March 1985 and the other in January 1990, the primary plan is that of the parent born in:

- A. March 1985, being the older of the two parents
- B. January 1990, having the earlier birthday in the year
- C. either, at the custodial parent's written election
- D. March 1985, unless a court order directs otherwise

78. Medicaid is best described as a program that is:

- A. jointly funded federally and by the states
- B. funded entirely by federal appropriations
- C. funded through beneficiary payroll contributions
- D. administered uniformly across all fifty states

79. Subrogation prevents:

- A. an insured recovering twice for the same loss
- B. an insurer denying a claim without investigation
- C. a provider billing above the customary charge
- D. a member holding two plans covering one expense

80. An employee of a Texas employer that has not subscribed to workers compensation:

- A. is automatically covered by a state assigned risk pool
- B. receives benefits directly from the Department of Insurance
- C. may have no workers compensation entitlement at all
- D. must purchase individual occupational coverage by law

81. Field underwriting fails most clearly when an agent:

- A. asks an applicant to clarify an ambiguous answer
- B. decides a disclosed condition is too minor to record
- C. observes the applicant appears unwell and notes it
- D. declines to submit business known to be misrepresented

82. A conditional receipt issued with premium means the insurer is on risk:

- A. from the date the policy is finally issued
- B. from the date of delivery to the policyowner
- C. unconditionally, for a stated number of days
- D. from the application or examination date if insurable

83. An application correction made after submission requires:

- A. a fresh application signed by the applicant
- B. written approval from the insurer's medical director
- C. return of the application for the applicant's initials
- D. a supplementary statement signed by the agent alone

84. Which best describes the agent's duty regarding information gathered during the application process?

- A. It may be shared freely with other prospective clients

- B. It is confidential and subject to federal privacy requirements
- C. It becomes the agent's property once the policy issues
- D. It must be reported to the state insurance department

85. An agent who consistently submits applications that fail underwriting will most likely:

- A. be required to reimburse the insurer's examination costs
- B. face automatic revocation of the state license held
- C. be reported to the Medical Information Bureau
- D. lose the appointment with that insurer over time

86. A client indifferent to a policy's benefits but focused on how quickly funds can be withdrawn should prompt the agent to consider:

- A. filing a suspicious activity report as trained
- B. recommending a shorter surrender charge schedule
- C. increasing the face amount to justify the deposit
- D. referring the client to a competing insurer instead

87. Personal delivery of a policy is preferred over mailing because it:

- A. is required by federal law in every transaction
- B. transfers ownership rights to the policyowner
- C. permits explanation and creates a delivery record
- D. starts the contestable period on a documented date

88. An agent alters an insurer's illustration to show a more conservative projection. This is:

- A. acceptable, because the change favors the client
- B. prohibited, because the illustration is the insurer's representation
- C. acceptable if the agent initials the alteration

D. prohibited only where the change overstates values

89. A twisting allegation is most likely to succeed where the agent:

- A. presented only the premium saving in a replacement
- B. provided a complete written comparison of both policies
- C. advised the client to retain the existing coverage
- D. notified the existing insurer of the proposed replacement

90. Which is NOT a warning sign of a stranger-originated life insurance arrangement?

- A. A third party funding the premium payments
- B. A face amount unrelated to any demonstrated need
- C. An intention to assign ownership soon after issue
- D. An applicant purchasing coverage on their own life

91. An applicant is entitled to know the nature and scope of an investigative consumer report:

- A. on request made to the insurer
- B. automatically, before any report is ordered
- C. only after coverage has been declined
- D. only through the reporting agency directly

92. The agent's signature on an application represents that:

- A. the agent has verified every answer independently
- B. the answers were recorded as the applicant gave them
- C. the agent guarantees the applicant's insurability
- D. the agent accepts liability for any misstatement

93. An agent collects an initial premium and holds it in a personal account for several days. This is:

- A. acceptable where the funds are eventually transmitted
- B. acceptable provided no interest is earned on them
- C. a technical breach carrying no disciplinary risk
- D. commingling, prohibited regardless of the outcome

94. Which correctly states the effect of the entire contract provision on an agent?

- A. The agent may waive a provision with client consent
- B. The agent may extend coverage pending underwriting
- C. The agent may not alter the contract or waive provisions
- D. The agent may amend the application after submission

95. A replacement occurs where existing coverage is, in connection with a new purchase:

- A. retained unchanged while additional coverage is added
- B. reduced in value or converted to extended term
- C. assigned to a lender as security for a loan
- D. amended to add a new contingent beneficiary

96. Which consequence follows automatically from replacing an existing life policy?

- A. A new contestable period begins on the new coverage
- B. The existing insurer must refund all premiums paid
- C. The new policy is issued at the original issue age
- D. The agent forfeits the first year commission earned

97. The conservation process in a replacement transaction refers to:

- A. the agent retaining a copy of all sales material used
- B. the replacing insurer holding premium in escrow
- C. the Department reviewing the transaction before issue
- D. the existing insurer responding to retain its policyholder

98. Which statement about anti-money laundering obligations is correct?

- A. They apply to every insurance product without exception
- B. They apply only where the client pays entirely in cash
- C. They attach to cash value and investment products
- D. They are enforced solely by state insurance departments

99. An insurer that accepts an application containing a blank question and issues the policy:

- A. may deny a claim relating to the missing answer
- B. has generally waived that question entirely
- C. may rescind the contract within two years
- D. must return all premiums received to the applicant

100. An applicant who is a minor generally cannot form a valid insurance contract because minors are:

- A. unable to demonstrate any insurable interest
- B. prohibited from paying premiums under state law
- C. not competent parties for contracting purposes
- D. excluded from coverage by the insuring clause

101. A Texas licensee who completes only twenty of the required continuing education hours faces:

- A. automatic revocation of the license held
- B. a written reprimand entered on the record
- C. suspension until the shortfall is corrected

D. a fine assessed for each deficient hour

102. The Texas license this study guide prepares candidates for is formally titled:

- A. General Lines Life, Accident, Health and HMO Agent
- B. Life Agent, covering life products and annuities
- C. Personal Lines Life and Health Producer
- D. Resident Insurance Producer, Life and Health Lines

103. Which body sets the passing standard for the Texas licensing examination?

- A. The examination vendor administering the test
- B. The National Association of Insurance Commissioners
- C. The Texas Legislature by statutory enactment
- D. The Texas Department of Insurance

104. An agent placing business with an unauthorized insurer exposes the client principally because:

- A. the premium charged will necessarily be higher
- B. the transaction sits outside guaranty association protection
- C. the policy cannot be enforced in any Texas court
- D. the agent's commission must be refunded in full

105. Which is a fraternal benefit society under the Texas Insurance Code?

- A. A membership organization operating on a lodge system
- B. A stock insurer distributing shareholder dividends
- C. A mutual insurer owned by its policyholders
- D. A reciprocal exchange managed by an attorney in fact

106. A Texas agent uses company letterhead the insurer never withdrew after ending the appointment, and a client relies on it. The insurer may be bound because of:

- A. express authority stated in the agency agreement
- B. implied authority reasonably necessary to the role
- C. apparent authority the insurer allowed to persist
- D. fiduciary authority over funds the agent received

107. Which statement about the Texas Guaranty Association is correct?

- A. It may be cited to reassure a concerned prospect
- B. It may be mentioned where the limits are stated accurately
- C. It may not be referenced in any sales presentation
- D. It may be described in written material but not verbally

108. The Guaranty Association limit for other supplemental health coverage, such as Medicare supplement, is:

- A. \$200,000 per individual covered
- B. \$300,000 per individual covered
- C. \$100,000 per individual covered
- D. \$500,000 per individual covered

109. An agent who shares part of a commission with a client to help them afford coverage has committed:

- A. twisting, by inducing an unnecessary purchase
- B. commingling, by mixing funds improperly
- C. defamation, by disparaging a competing insurer
- D. rebating, prohibited even at the client's request

110. An insurer charging two applicants of the same class and hazard different premiums has engaged in:

- A. lawful underwriting based on individual assessment
- B. unfair discrimination prohibited by the Insurance Code
- C. rebating, by conferring an unlawful inducement
- D. twisting, by misrepresenting the competing product

111. A Texas agent must maintain records of insurance transactions in order to:

- A. make them available to the Department on request
- B. support the agent's commission claims against insurers
- C. satisfy federal rather than state recordkeeping law
- D. establish the contestable period for issued policies

112. Which act by the Commissioner requires notice to the affected party?

- A. Adopting a rule of general application
- B. Publishing a consumer information bulletin
- C. Approving a policy form filed by an insurer
- D. Holding a hearing on an alleged violation

113. A Texas life policy's grace period may include:

- A. a waiver of the overdue premium if death occurs
- B. an automatic reduction in the face amount payable
- C. an interest charge on the unpaid premium if specified
- D. an extension to sixty days at the insurer's discretion

114. Under Texas law a life policy must state that it is incontestable not later than:

- A. one year from its effective date
- B. two years from its effective date
- C. three years from its effective date
- D. five years from its effective date

115. A Texas life insurer must make policy loans available:

- A. immediately upon issue where cash value exists
- B. after premiums for one full year have been paid
- C. after premiums for five full years have been paid
- D. after premiums for three full years have been paid

116. Which Texas requirement applies to a life insurance advertisement?

- A. Prior written approval by the Commissioner before use
- B. It must not be untrue, deceptive, or misleading overall
- C. Disclosure of the agent's commission on the product
- D. Inclusion of the insurer's most recent solvency rating

117. A Texas replacing agent must ordinarily provide the replacing insurer with:

- A. a copy of the existing policy being replaced
- B. the existing insurer's written consent to replace
- C. copies of sales material used in the presentation
- D. a certified financial statement for the applicant

118. A Texas group life certificate holder whose employment ends may convert:

- A. within a stated period, without evidence of insurability

- B. at any time during the following five years
- C. only where the employer's group policy is terminating
- D. only after providing satisfactory evidence of insurability

119. The Texas nonforfeiture requirement applies to a life policy that:

- A. is issued to a group rather than an individual
- B. accumulates a cash value during its term
- C. contains an accidental death benefit rider
- D. is written on a participating dividend basis

120. A Texas insurer offering an accelerated benefit must disclose that the payment:

- A. reduces the death benefit later payable
- B. terminates the policy at the time of payment
- C. is taxable as ordinary income to the insured
- D. requires the beneficiary's written consent first

121. A Texas health plan's coverage of a newborn child begins:

- A. when the additional premium has been received
- B. when the parent notifies the carrier of the birth
- C. on the first day of the following plan month
- D. at birth, without requiring prior enrollment

122. Chemical dependency treatment in a Texas health benefit plan is:

- A. excluded unless the employer elects to add it
- B. covered only after a twelve month waiting period
- C. a mandated benefit the plan must provide
- D. limited to outpatient counseling services only

123. A Texas Medicare supplement purchaser returning the policy within thirty days is entitled to:

- A. a refund of premium less an administrative charge
- B. a prorated refund covering the unused portion
- C. a credit toward another policy from the same insurer
- D. a full refund of premium, with no questions asked

124. An insurer conducting HIV testing on a Texas applicant must use:

- A. a separate consent form meeting the applicable rule
- B. the general medical authorization already signed
- C. verbal consent recorded in the underwriting file
- D. consent obtained from the applicant's physician

125. A Texas small employer carrier may condition coverage on:

- A. the health status of the group's least healthy member
- B. minimum participation and employer contribution levels
- C. the group's claims experience over the prior three years
- D. the employer agreeing to a three year renewal commitment

126. Preventive services required as essential health benefits must be provided:

- A. after the annual deductible has been satisfied
- B. at fifty percent coinsurance until the maximum
- C. without cost sharing when delivered in network
- D. only when a physician documents medical necessity

127. Which describes the metal tiers used for Marketplace plans?

- A. They rank the clinical quality of participating providers
- B. They describe the share of expected costs the plan pays
- C. They indicate the size of the plan's provider network
- D. They reflect the insurer's financial strength rating

128. A Texas HMO enrollee who permanently relocates outside the service area may:

- A. retain coverage indefinitely at the same premium
- B. convert automatically to an indemnity policy
- C. require the HMO to contract with local providers
- D. have coverage non-renewed on that ground

129. Texas regulates health maintenance organizations principally under:

- A. their own chapters of the Insurance Code and Title 28
- B. the same provisions governing life insurers generally
- C. federal law exclusively, with no state oversight
- D. the small employer health benefit plan provisions

130. An evidence of coverage differs from an insurance policy because it:

- A. requires no approval before an HMO may use it
- B. may be amended by the enrollee at any time
- C. describes services the enrollee is entitled to receive
- D. is issued only to employers rather than individuals

Practice Exam 4: Answer Key and Explanations

- 1. D** — Reduced paid-up applies the accumulated cash value as a single premium to purchase a fully paid-up permanent policy at a smaller face amount, lasting for the insured's whole life with nothing further to pay. Extended term instead preserves the full original face amount but only for a limited period. The owner trades face amount for permanence.
- 2. B** — More frequent premium modes increase the total paid across a year, because the insurer loses investment earnings on money received later and incurs additional administrative expense. Annual payment is always the cheapest in total. Candidates who reason that smaller payments must be cheaper overall answer these questions incorrectly. Annual payment is always cheapest in total.
- 3. C** — A participating policy is eligible for dividends representing a return of premium the insurer did not need, and dividends can never be guaranteed. Nonparticipating policies pay none. Separate account direction belongs to variable products, and premium flexibility belongs to universal life, so neither describes a participating whole life contract. Dividends can never be guaranteed in advance.
- 4. B** — Limited-pay whole life compresses the full lifetime cost into a shorter payment window, so a fifteen-pay policy is fully paid after fifteen years while coverage continues for life. Term expires without permanence, ordinary whole life requires premiums to the maturity age, and universal life offers flexibility rather than a guaranteed paid-up date.
- 5. D** — Monthly deductions for cost of insurance and expenses continue regardless of what the owner pays in. Where funding is minimal and credited interest falls, the account can be consumed until nothing remains to cover those deductions, and the policy lapses despite the owner believing permanent coverage was securely in force.
- 6. A** — Option B pays the face amount plus the accumulated cash value, so the insurer's net amount at risk does not shrink as the account grows and the cost of insurance charged remains correspondingly higher. Option A pays a level death benefit, and the insurer's exposure decreases as cash value accumulates over time.
- 7. D** — Convertibility permits exchange of a term policy for permanent coverage without new evidence of insurability, which is precisely why it protects an insured whose health has since declined. Conversion is typically available at the original age, costing more at conversion, or at attained age, which costs less initially but reflects current age.
- 8. B** — Joint life insures two or more lives under one contract and pays when the first insured dies, at which point the policy terminates. Because the insurer must contemplate paying on whichever life fails first, the poorer of the two risks effectively drives pricing, and a seriously impaired applicant may be declined outright.
- 9. A** — Term insurance provides pure protection and accumulates no cash value at all, so nonforfeiture provisions have nothing to preserve and policy loans are not required. Every premium dollar beyond expenses pays for mortality risk alone, which is why term delivers the largest death benefit per dollar of any life product available.

10. C — An indexed policy credits interest by reference to an external index while the insurer retains the funds in its own general account, using the index purely as a measuring device. Because no direct investment in the index occurs, indexed products generally are not securities, unlike variable products using separate accounts.

11. B — The policy summary sets out the specific contract's premiums, benefits, and values, while the Buyer's Guide explains life insurance in general terms. Both are delivery requirements attached to the sale, and the purpose of the pair is to let a buyer compare competing products on a genuinely common basis. Both documents are delivery requirements, not marketing.

12. C — The insuring clause, usually appearing on the face page, carries the insurer's core promise to pay the stated benefit on receipt of due proof of the insured's death, subject to the policy terms. The consideration clause instead identifies the premium and application statements the applicant gives in exchange. It appears on the policy's face page.

13. D — A class designation names a category rather than individuals, so it need not be amended as a family grows or changes. It raises the question of how a deceased member's share is treated, which per stirpes and per capita answer differently, and it remains entirely valid without listing individual names.

14. A — Where no primary, contingent, or tertiary beneficiary survives, proceeds are payable to the insured's estate, exposing them to probate delay and to the claims of estate creditors. Careful designation exists precisely to avoid that outcome, which is why contingent and tertiary beneficiaries are worth naming at issue. Naming contingent beneficiaries prevents that outcome.

15. A — The grace period allows a stated number of days after a premium due date during which the premium may still be paid and the policy remains in full force. If the insured dies during it, the death benefit is payable with the unpaid premium deducted from the proceeds paid out.

16. B — An accidental death rider pays an additional amount only where death results from accident within a stated period following that accident. Death from illness triggers the base policy alone, so a question describing an insured who dies of disease is testing whether the additional amount will wrongly be paid. Illness never triggers the additional rider amount.

17. C — A collateral assignment transfers policy rights only to the extent of a debt, and it ends once that debt is satisfied, with the balance of rights remaining with the owner throughout. An absolute assignment instead transfers all ownership rights permanently to the assignee, who then controls the contract entirely. The owner retains all remaining policy rights.

18. D — The suicide clause conventionally runs two years from issue. Thirty months places the death outside that period, so suicide is treated as any other cause and the full benefit is payable. Within the period, the insurer would instead refund the premiums paid and pay no death benefit at all. The period runs from issue, not from delivery.

19. B — Guaranteed insurability permits purchase of additional coverage at specified future dates or on stated life events without evidence of insurability. Its value is realized precisely by an insured whose

health later deteriorates, and it is not an open-ended right exercisable at any moment the owner happens to choose. It is not an open-ended purchase right.

20. A — An accelerated payment advances part of the death benefit during life, reduces what the beneficiary later receives, and may affect eligibility for needs-based public benefits because the money received counts as a resource. Both consequences must be disclosed before a client elects to accelerate any portion of the benefit. Both consequences must be disclosed beforehand.

21. C — The waiver of premium waiting period runs from the onset of the qualifying total disability, and premiums remain due until it has elapsed. Once satisfied, the insurer waives premiums while the disability continues and coverage remains in full force, with premiums paid during the waiting period commonly refunded to the owner.

22. D — Misstatement of age is a proportionality remedy rather than a forfeiture. The amount payable is adjusted to what the premium actually paid would have purchased at the correct age. The policy is not voided, no fraud need be shown, and the rule applies whether age was understated or overstated. Overstated age produces the same proportional adjustment.

23. C — Four elements form a contract: offer and acceptance, consideration, competent parties, and legal purpose. Regulatory approval of policy forms is a separate statutory requirement rather than an element of contract formation, and a contract missing any of the four genuine elements is not enforceable regardless of any filing. Form approval is regulatory rather than contractual.

24. A — Competent parties means both sides are legally capable of contracting. On the insurer's side, competence means holding a valid certificate of authority to transact insurance in the state, and an unlicensed entity cannot form a valid insurance contract. On the applicant's side it excludes minors and those legally incompetent. Minors and incompetent persons are excluded likewise.

25. D — The insurer drafts every word and the applicant either accepts or declines, so the doctrine of contra proferentem construes genuine ambiguity against the drafter and in favor of the insured. This is why insurers invest heavily in precise definitions, and why an ambiguously worded exclusion tends to fail on challenge.

26. B — Only the insurer makes a promise that can be enforced, and it may be sued for failing to pay covered claims. The policyowner promises nothing, since no one can compel payment of a premium; failure simply ends the coverage. Candidates who assume mutual promises are required answer this incorrectly. No one can compel payment of a premium.

27. B — Application statements are representations, true to the best of the applicant's knowledge, and only a material inaccuracy affects the contract. Materiality means the insurer would have declined, rated, or issued on different terms had it known. A trivial discrepancy gives the insurer no remedy even inside the contestable period. Only material inaccuracies give the insurer a remedy.

28. D — Express authority comprises the powers explicitly granted in the agency contract, such as soliciting applications, collecting initial premiums, and delivering policies. Implied authority covers

what is reasonably necessary to exercise those powers, and apparent authority arises from appearances the insurer permits the public to rely upon. Written grants define what the agent may do.

29. C — Period certain pays a level amount for a stated number of years regardless of whether the annuitant survives, exhausting the fund at the end of the term. Because it carries no longevity risk it offers no protection against outliving the money, which life-contingent options are specifically designed to provide. The fund is exhausted when the term ends.

30. A — The annuitant is the person whose life measures the payments, equivalent in function to the insured under a life policy, while the owner holds the contractual rights. As with life insurance the two need not be the same person, and neither age nor entity status is prescribed by law. Third-party ownership is entirely permissible here.

31. C — Surrender charges commonly decline across a schedule of several years and eventually disappear altogether. Most contracts also permit a free withdrawal of a stated percentage annually without charge. A client who may need the money soon is poorly matched to a deferred annuity, and recognizing that mismatch is a suitability issue.

32. A — A fixed annuity credits a guaranteed minimum rate and pays a fixed dollar amount during the payout phase, so the insurer bears the investment risk. A variable annuity transfers that risk to the owner through separate account subaccounts and requires a securities registration in addition to the insurance license. Guarantees are what shift the risk to the insurer.

33. D — Keogh plans, sometimes called HR-10 plans, cover owner-employees of unincorporated businesses. Section 401(k) arrangements serve employees of for-profit employers, section 403(b) plans serve public school and certain nonprofit employees, and section 457 plans serve state and local government employees under their own distribution rules. Matching employer type to plan resolves these questions reliably every time.

34. B — Qualified plans must not discriminate in favor of highly compensated employees, and in exchange they receive favorable tax treatment through pre-tax deductible contributions and tax-deferred growth. The trade is regulation, including contribution limits, participation rules, and restrictions on early access, rather than guaranteed returns or identical contributions. Regulation is the price of favorable tax treatment.

35. C — Basis arises because the money was already taxed going in. A nonqualified annuity is funded with after-tax dollars, so only the growth is taxable on distribution and the exclusion ratio splits each annuitized payment between untaxed basis and taxable gain. Qualified arrangements create no basis at all. Qualified arrangements create no basis at all.

36. A — The employer deducts the premium as a business expense. For the employee, the cost of coverage up to a federally set threshold is not treated as income, while the cost above it is imputed income and taxable. The death benefit itself remains generally income-tax-free to the beneficiary. The threshold figure is federally set and changes.

37. D — Pre-annuitization withdrawals are treated as coming from gain first and are fully taxable until the accumulated gain is exhausted. This reverses the exclusion ratio treatment applied after annuitization, where each payment is part untaxed basis and part taxable gain, and the reversal is deliberately tested on the examination. Ordering rules reverse entirely at annuitization.

38. A — A surviving spouse caring for the deceased worker's child receives benefits until the youngest child reaches the qualifying age, after which they stop and do not resume until the spouse reaches retirement age. That interval is the blackout period and can run for decades, justifying private coverage. The gap is known as the blackout period.

39. B — Whoever paid with untaxed dollars pays tax on the benefit. Because business overhead expense premiums are deducted as an ordinary business expense, the benefits are taxable to the business. Disability buy-sell and key employee coverages reverse this, with non-deductible premiums producing benefits received free of tax. Untaxed money produces taxable benefits out.

40. C — Modified Endowment Contract status changes only the treatment of lifetime distributions, which become gain-first and may carry a penalty before a stated age. The death benefit remains generally income-tax-free to the beneficiary. Candidates frequently answer that the death benefit loses its favorable treatment, which is incorrect. Only living distributions lose favorable treatment.

41. B — Medical and paramedical examinations are ordered according to underwriting guidelines based principally on the applicant's age and the face amount applied for. An MIB entry signals where to investigate further rather than automatically triggering an examination, and neither an applicant request nor an agent recommendation determines the requirement. Guidelines rather than individual requests govern this.

42. D — An impairment or exclusion rider removes coverage for a named condition while the rest of the policy remains intact, functioning as an underwriting alternative to declining the applicant. The applicant obtains coverage for everything else, which is ordinarily far better than no policy, and the exclusion is disclosed and accepted at issue.

43. D — Where no premium accompanied the application, coverage does not attach until delivery, so the insurer requires confirmation that health has not deteriorated during underwriting. If it has, the insurer may reconsider or decline. Where a receipt already attached coverage with premium, no such statement is required at delivery. Coverage attaches at delivery in that situation.

44. B — Apparent authority arises where the insurer allows an appearance of authority to continue and a member of the public reasonably relies on it, binding the insurer to acts it never actually authorized. The doctrine exists to protect a person who relied on appearances the insurer itself permitted to remain in place.

45. A — Inspection or consumer reports gathered by a reporting agency cover finances, occupation, and lifestyle. Physician statements and paramedical examinations address medical history and current health, and the MIB reports coded prior findings from member insurers rather than financial or lifestyle information about the applicant. Medical sources address health rather than lifestyle.

46. C — Warning signs include a third party funding premiums, a face amount unrelated to any demonstrated need, an applicant with no independent reason for coverage, and an intended ownership transfer soon after issue. An agent who recognizes the pattern and submits the business anyway becomes a participant in the arrangement. Submitting anyway makes the agent a participant.

47. C — The probationary period runs from the policy's effective date and excludes sickness beginning during it, while accidents are ordinarily covered immediately. The elimination period runs from the onset of each disability and applies to every claim, and the benefit period limits how long payments continue once they have started. Accidents are ordinarily covered from day one.

48. D — An income replacement definition measures disability by loss of earnings rather than by ability to perform occupational duties, so a partial return to work at reduced income produces a proportionate benefit. Own occupation and any occupation both test duties, and presumptive disability deems total disability on specified catastrophic losses. Partial return to work is therefore not penalized.

49. B — Insurers deliberately replace only part of income, commonly around sixty to seventy percent, because full replacement would remove the financial incentive to return to work. This is a design feature rather than a shortfall, and the relation of earnings to insurance provision reinforces it by reducing overinsured benefits. Full replacement would remove the incentive to recover.

50. A — Accidental death and dismemberment responds only to accident, so death or impairment arising from illness produces no benefit at all. A cardiac event is a medical cause rather than an accident. The coverage is narrow by design and is never a substitute for life or disability protection. It is never a substitute for life coverage.

51. A — Basic surgical plans pay according to a schedule assigning a stated amount to each listed procedure, and they pay from the first dollar without a deductible. Their weakness is the low maximum, which leaves a catastrophic claim largely unfunded. Major medical instead applies cost sharing in exchange for a very high maximum.

52. C — The member pays the \$500 deductible first, leaving \$4,000 subject to coinsurance. Twenty percent of \$4,000 is \$800, so the member's total is \$1,300 and the plan pays \$3,200. Applying coinsurance to the full charge before subtracting the deductible produces \$900, which is the distractor built around that common error.

53. B — A health reimbursement arrangement is funded solely by the employer, and employees may not contribute to it. Reimbursements for qualified medical expenses are not taxable income to the employee. Because the employer funds and owns the arrangement, it does not travel with a departing employee unless the employer permits carryover.

54. D — The health savings account belongs to the individual, so it is portable when employment ends, and unused balances roll over indefinitely rather than expiring. Reimbursement arrangements are employer-owned and not portable, and flexible spending accounts are generally use-it-or-lose-it, so only the health savings account offers both features together. Only that account answers yes to both questions.

55. D — The primary care physician acting as gatekeeper coordinates the member's care and issues referrals to specialists, which is a defining feature of the HMO and point of service models. A PPO uses no gatekeeper, allowing direct specialist access, and claims payment and premium setting are plan administration functions. Referrals distinguish the gatekeeper models sharply.

56. A — An HMO generally covers nothing obtained outside its network except in an emergency, which is the sharpest distinction from the PPO and point of service models. A PPO covers out-of-network care at a reduced benefit level, and a point of service plan does the same while retaining the gatekeeper requirement.

57. C — Benefits under a tax-qualified long-term care policy are generally not taxable income, and premiums may count as deductible medical expenses within limits rising with the insured's age. The trade for that treatment is a standardized benefit trigger requiring two activities of daily living or severe cognitive impairment. The trigger standard is what earns the treatment.

58. B — The ninety-day element is a prognosis requirement: the loss of two activities of daily living must be expected to last at least ninety days. It is not a waiting period and is not the same as the elimination period, which is a separate contractual term and is frequently confused with it.

59. C — A Partnership program links approved policies to Medicaid eligibility, permitting a person who exhausts benefits to protect assets equal to the benefits paid rather than spending them down. The arrangement exists because private insurance has already reduced what the state would otherwise pay for that person's care. The state concedes what private insurance already saved.

60. B — COBRA applies to employers with twenty or more employees, and it allows a qualified beneficiary losing group health coverage to continue it at their own expense. The person pays the full premium covering both former shares plus a small administrative charge, which is why the coverage feels unexpectedly expensive. The full premium is why many decline it.

61. A — Short-term medical provides temporary coverage for a defined period, bridging a gap such as the interval between jobs. It is medically underwritten, typically excludes preexisting conditions, and is not designed as ongoing coverage. It falls within the excepted benefits category and is therefore outside the major medical reform requirements. Excepted benefit status is what permits underwriting.

62. D — Vision plans typically cover a routine examination at a set interval plus an allowance toward lenses and frames or contact lenses, with the member paying anything above the allowance. Dental plans instead tier services into preventive, basic, and major categories paid at descending percentages, with a low annual maximum. Orthodontia is usually a separate benefit entirely.

63. B — Worksite coverage is offered through the employer but paid entirely by the employee, typically by payroll deduction, with the employer providing access and administration rather than funding. Because it is sold to a group, underwriting is often simplified or guaranteed issue at initial enrollment while the employee retains an individual certificate.

64. A — Where the insurer accepts a late premium without requiring an application, the policy is reinstated immediately. Where it requires an application and issues a conditional receipt, reinstatement

occurs on approval, or automatically after a stated number of days if the insurer has not declined it in the meantime. The distinction turns on what the insurer requires.

65. D — The provision requires notice within twenty days after the loss, or as soon thereafter as is reasonably possible, so a claimant genuinely unable to give notice within twenty days is not automatically barred. The insurer must then supply claim forms within fifteen days of receiving that notice. Reasonableness is judged on the claimant's circumstances.

66. C — Other insurance in this insurer is an optional provision addressing benefits where the insured holds more than one policy with the same company, permitting the insurer to limit total coverage and refund excess premium. Insurance with other insurers is a parallel optional provision covering coverage held with different companies. Excess premium is refunded where coverage is limited.

67. C — The physical examination and autopsy provision permits the insurer, at its own expense, to examine the insured as often as reasonably necessary while a claim is pending and to require an autopsy where not forbidden by law. It may not charge the insured for either, and state law may prohibit autopsy.

68. B — Change of occupation is a proportionality remedy rather than a forfeiture. Moving to more hazardous work reduces benefits to the amount the premium paid would have purchased at that higher-risk rate. The insurer does not deny the claim, bill the difference, or void the policy for failure to notify. Notification failure does not forfeit the coverage.

69. D — Guaranteed renewable coverage must be renewed to the stated age, but premiums may be raised provided the increase applies to an entire class rather than to one insured whose health or claims experience worsened. That class restriction is precisely what preserves the practical value of the renewal guarantee. Singling out one insured is never permitted.

70. A — A social insurance supplement rider pays an amount that reduces or ceases if the insured is awarded Social Security disability benefits, coordinating private and public coverage rather than duplicating it. It bridges the period while a Social Security claim is pending or after it has been denied altogether. It bridges the wait for a public decision.

71. A — Pre-authorization requirements are ordinarily enforced through a reduced benefit rather than outright denial, so a member who skipped the step for otherwise covered care is usually paid something at a penalty. Coverage is not canceled, and the distinction between reduction and denial is deliberately tested on the examination. Reduction and denial are materially different outcomes.

72. B — Major medical coverage subject to federal reform generally may not impose preexisting condition exclusions. Excepted benefits fall outside those requirements, and the category includes hospital indemnity, specified disease, short-term medical, standalone dental and vision, and disability income, all of which may still exclude preexisting conditions. Identifying the product category answers these questions.

73. C — A critical illness policy names several conditions such as heart attack, stroke, and organ failure, and pays a lump sum on diagnosis that the insured may spend on anything. A specified disease policy

responds to a single named condition, most commonly cancer, and pays nothing for any other diagnosis. Neither replaces comprehensive medical coverage.

74. D — Within a benefit period, hospital days one through sixty are covered in full after the deductible, days sixty-one through ninety carry daily coinsurance, and beyond ninety the beneficiary may draw on sixty lifetime reserve days that are never replaced once used. Specific dollar amounts change annually. Only day counts, never dollar figures, stay stable.

75. D — Part B covers physician services, outpatient care, laboratory work, durable medical equipment, and preventive services. Inpatient hospital charges fall under Part A, outpatient prescription drugs under Part D, and long-term custodial care is covered by no part of Medicare at all, which is why long-term care insurance exists. No part of Medicare covers custodial care.

76. C — The one-time Medigap open enrollment period begins when the beneficiary is both age sixty-five or older and enrolled in Part B, and it runs for six months. During it the insurer must issue any plan it offers regardless of health, cannot refuse, and cannot charge more for medical history. Outside that window underwriting applies normally.

77. 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 March and that plan is primary. Where parents are separated or divorced, a court order allocating responsibility for coverage governs instead of the rule. Year of birth is entirely irrelevant here.

78. A — Medicaid is jointly funded by federal and state government and administered by states within federal requirements, so eligibility and covered benefits vary between them. Medicare, by contrast, is an entitlement earned through payroll work credits and administered federally on uniform terms across the whole country. State variation is why Texas rules must be checked.

79. A — Subrogation allows an insurer that has paid a claim to pursue the party responsible, preventing the insured from recovering both from the plan and from the wrongdoer for the same loss. It serves the same principle as coordination of benefits, that insurance indemnifies actual loss and is never a source of gain.

80. C — Texas does not require most private employers to carry workers compensation, and an employee of a non-subscribing employer may therefore have no entitlement under that system. The employer loses important legal protections and becomes exposed to suit, but no state pool automatically supplies the coverage the employer declined. Non-subscription removes the employer's tort protection too.

81. B — An agent who decides a disclosed condition is too minor to record has not simplified the file; the agent has created a misrepresentation the insurer will struggle to enforce and a professional liability for themselves. Clarifying answers, recording observations, and declining misrepresented business are all correct field underwriting conduct. The omission becomes the agent's professional liability.

82. D — A conditional receipt attaches coverage from the later of the application date or any required medical examination date, but only where the applicant proves insurable as a standard risk. A binding

receipt would place the insurer on risk unconditionally for a stated period regardless of eventual insurability. Insurability is the condition doing all the work.

83. C — Where the insurer needs a change after submission, the corrected application is returned for 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, which undermines the insurer's position at claim.

84. B — Information gathered during the application process is confidential and subject to federal privacy requirements, including the notice and opt-out obligations under Gramm-Leach-Bliley and the medical authorization rules governing health information. It does not become the agent's property and is not routinely reported to the state regulator. Confidentiality survives the end of the relationship.

85. D — Field underwriting costs the insurer money when business consistently fails, and an appointment is a commercial relationship the insurer may end. Poor selection is not by itself a licensing violation, does not trigger MIB reporting, and does not create personal liability for the cost of underwriting the declined applications. Appointments are commercial relationships insurers may end.

86. A — Indifference to product features combined with keen interest in surrender terms is a recognized money laundering indicator, alongside third-party payment, unusual cash or structured payments, and early surrender accepted despite penalties. Agents selling cash value and annuity products receive training and must report suspicious activity when they observe it. Recognizing the pattern is what training teaches.

87. C — Personal delivery lets the agent explain the death benefit, premium, riders, exclusions, and any rating applied, and it produces a signed delivery receipt recording the date, which matters because the free look ordinarily runs from delivery. The contestable period runs from the policy date rather than from delivery. Explanation matters most on a rated policy.

88. B — 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 it more conservative. Doing so makes the agent the author of a projection nobody approved, exposing both the agent and the insurer to a misrepresentation claim.

89. A — Twisting is inducing replacement through misrepresentation or an incomplete comparison, and presenting only a premium saving while omitting the restarted contestable period, restarted suicide clause, and current-age pricing is exactly that. Complete comparison, advising retention, and notifying the existing insurer are all proper conduct. Omitting the disadvantages is what makes it twisting, and a premium saving alone never justifies replacing.

90. D — Insurable interest exists automatically in one's own life, so an applicant insuring themselves for an appropriate amount raises no concern. 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. Insurable interest exists automatically in one's own life.

91. A — The Fair Credit Reporting Act requires written notice that a report may be obtained, and entitles the applicant to learn the nature and scope of an investigative report on request. Where a report causes decline or rating, the applicant must also be told and given the reporting agency's identity. Accuracy of the information is what the Act protects.

92. B — The agent's signature represents that the answers were recorded as the applicant actually gave them, which is why signing on a client's behalf is forgery and why corrections require the applicant's initials. It is not a verification of the answers, a guarantee of insurability, or an assumption of liability. Corrections require the applicant's own initials.

93. D — 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 whether any money is lost, because once funds are combined the regulator cannot verify what became of them.

94. C — No change to the contract is effective unless made in writing and approved by an executive officer of the insurer, so an agent cannot alter terms, waive a provision, or extend coverage beyond the policy's terms, however senior or well-intentioned. Amending an application after submission requires the applicant's initials. Only an executive officer may approve changes.

95. B — Replacement reaches far more than outright cancellation. Coverage terminated, lapsed, surrendered, reduced in value, or converted to paid-up or extended term in connection with a new purchase has been replaced. Retaining a policy unchanged while adding coverage is not replacement, and assignment and beneficiary changes are unrelated acts. Reading for what happens to the old policy decides it.

96. A — Replacement restarts the contestable period and the suicide clause on the new policy, prices coverage at the client's current age rather than the original age, and incurs new front-end costs the old policy had already absorbed. No premium refund occurs and the agent earns commission either way. New front-end costs are incurred as well.

97. 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. That process is called conservation, and it lets the applicant decide with both positions in front of them rather than one. The applicant then decides with both positions available.

98. C — Anti-money laundering programs attach to products with cash value or investment features, principally permanent life insurance and annuities, because those accept large sums and can be surrendered for clean funds. Pure term, accident-only, and limited benefit products fall outside the requirement regardless of how the client pays. Payment method does not determine whether they apply.

99. B — An insurer issuing on an application with unanswered questions is generally held to have waived them and cannot later rely on the omission to defeat a claim. The gap becomes the insurer's problem rather than the applicant's, which is why an incomplete application should never be submitted for underwriting. Incomplete applications should never be submitted.

100. C — Competent parties is one of the four contract elements, and it excludes minors, persons adjudged mentally incompetent, and persons under the influence of drugs or alcohol at the time of contracting. Insurable interest, premium payment capacity, and the insuring clause address entirely different questions from contractual competence. Intoxication at signing has the same effect.

101. D — 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. A licensee who does not complete the hours, pay the fine, and renew within ninety days of expiration has the license canceled entirely. Renewal and compliance operate as one requirement.

102. A — Texas issues a General Lines Life, Accident, Health and HMO Agent license, and there is no separate life-only and health-only pair at this level. A narrower Life Agent license with its own shorter examination exists, but it does not authorize selling health products, Medicare supplements, or HMO coverage. There is no separate life-only and health-only pair.

103. D — The Texas Department of Insurance sets the licensing requirements and the passing standard and issues the license, while the examination vendor develops and administers the test under contract. Fingerprinting runs through a separate vendor, and the application is filed electronically after the candidate passes the examination. Four organizations handle four separate steps.

104. B — An insurer without a certificate of authority is unauthorized, and business placed with it sits outside the state's regulatory oversight and outside guaranty association coverage if the company later fails. That loss of protection is the substantive exposure, rather than any automatic effect on premium or commission. Regulatory oversight is lost along with it.

105. A — Fraternal benefit societies operate on a lodge system for the benefit of their members and are organized without profit, which distinguishes them from stock companies owned by shareholders and mutual companies owned by policyholders. Guaranty association coverage does not extend to fraternal benefit society certificates. Guaranty coverage does not extend to their certificates.

106. C — Apparent authority arises where the insurer permits an appearance of authority to continue and a member of the public reasonably relies on it, which can bind the insurer to acts it never authorized. The doctrine protects a client who relied on appearances the insurer itself failed to withdraw. Withdrawing the appearance is the insurer's responsibility.

107. C — Using the existence of the Association to induce a purchase is prohibited in any form, written or spoken. 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 when choosing between competing companies. Financial strength is the judgment consumers must exercise.

108. A — Other supplemental health coverage, including Medicare supplement policies, carries a \$200,000 limit per individual. Basic hospital, medical-surgical, and major medical coverage is limited to \$500,000, long-term disability and long-term care to \$300,000, and annuity benefits to \$250,000 in present value per individual life. Knowing which tier applies decides these questions reliably.

109. D — Rebating is offering any valuable consideration not specified in the policy as an inducement to purchase, and sharing commission with a client is a clear instance. It remains prohibited even where the client asks, and in most circumstances both the agent offering and the client accepting are in violation. Both parties are generally in violation together.

110. B — 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 remains lawful and is the entire basis of underwriting, so the violation lies in treating equivalent risks differently rather than in rating at all.

111. A — Texas requires agents to maintain records of insurance transactions and make them available to the Department on request. Records are the evidence that a transaction was conducted properly, and an agent who cannot produce them is poorly placed to answer a complaint whatever the underlying facts may actually have been.

112. D — The Department may investigate suspected violations and hold hearings, with notice given to the affected party. Adopting rules of general application, publishing consumer bulletins, and approving policy forms are administrative acts that do not target an individual licensee and therefore carry no individual notice requirement. Obstructing an examination is itself a violation.

113. C — The policy may charge interest on the unpaid premium during the grace period provided the rate is specified, and may stipulate that an overdue premium is deducted from any settlement if the insured dies during the period. The premium is deducted rather than waived, and the face amount is not reduced.

114. B — A Texas life policy must provide that a policy in force for two years from its date during the insured's lifetime is incontestable, except for nonpayment of premiums. An insurer may provide a shorter period than the statute prescribes but may never impose a more onerous one on the policyholder.

115. D — Loans must be made available at any time while the policy is in force after premiums for three full years have been paid and a cash value is available. Term life and pure endowment policies are not required to offer loans even where they happen to generate cash values. The requirement attaches to policy type, not value.

116. B — The governing standard is that an advertisement must not be untrue, deceptive, or misleading, judged by the overall impression it creates rather than by whether each individual statement is literally accurate. Arrangement, emphasis, and omission can mislead even where every sentence is defensible in isolation. Emphasis and omission can mislead by themselves.

117. C — The replacing agent presents the required replacement notice, obtains signatures, submits a statement identifying the coverage being replaced, and provides copies of any sales material, proposal, or comparison used, so the basis of the recommendation is on the record. The existing insurer's consent is never required. The existing insurer may then respond directly.

118. 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, and it disappears once the conversion window has closed. Attained age pricing reflects the current age.

119. B — The Standard Nonforfeiture Law applies to policies generating cash values, which in practice means permanent forms, and it requires a table of guaranteed values in the contract. Term insurance falls outside it because a policy accumulating no value has nothing to forfeit when premiums stop being paid. A guaranteed value table must appear in it.

120. A — An accelerated benefit advances part of the death benefit on a qualifying condition, and the essential disclosure is that the amount advanced reduces what the beneficiary later receives. It may also affect eligibility for needs-based public benefits. The policy does not terminate and beneficiary consent is not generally required. Public benefit eligibility may also be affected.

121. D — 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. The plan may later require notification of the birth and additional premium for coverage to continue beyond the initial statutory period.

122. C — 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. Cosmetic, experimental, and custodial care are not mandated benefits. Untreated dependency generates costs elsewhere anyway.

123. D — The purchaser may return a Medicare supplement policy within thirty days of receiving it and obtain a full refund of premium with no questions asked. Keeping a record of the date received and returning by certified mail with return receipt is advisable, because the burden of proving timely return falls on the consumer.

124. A — 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 that requirement. Results are confidential, disclosure is restricted, and sexual orientation may never be used in underwriting or inferred from proxies. Sexual orientation may never be used in underwriting.

125. B — Guaranteed issue does not mean issue on any terms. A carrier may impose minimum participation and minimum employer contribution requirements to prevent adverse selection, and may decline an employer failing them. The decline must rest on the arrangement itself, never on the health status of the people within the group.

126. C — 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 ordered to investigate an existing symptom is a different service and may attract normal deductible and coinsurance under the plan. Diagnostic testing is treated entirely differently.

127. B — Metal tiers describe actuarial value, meaning the share of expected costs the plan pays, and they say nothing about quality of care, network size, or the insurer's financial strength. A candidate

should not read a higher tier as a better plan in any sense other than cost sharing. Higher tiers mean lower cost sharing only.

128. D — An HMO delivers care through a defined network in a defined geography, so permanent relocation outside the service area is a legitimate ground for nonrenewal. Health status, volume of services used, and complaints to the Department are never permissible grounds, while nonpayment and fraud remain legitimate ones. Health status is never a permissible ground.

129. A — HMOs are governed by their own chapters of the Texas Insurance Code, with network adequacy and related requirements and rules throughout Title 28 of the Administrative Code. The separate framework exists because an HMO arranges and delivers care rather than only paying for services rendered by others. Arranging care rather than paying explains the framework.

130. C — An evidence of coverage sets out the services an enrollee is entitled to receive, the conditions attached, and the enrollee's rights, and it must be approved by the Department before use. Insurers issue policies, group insurers issue certificates under a master contract, and HMOs issue evidences of coverage. Departmental approval precedes any use of it.