

PRACTICE EXAM 5: 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 insured buys a whole life policy and elects the paid-up additions dividend option. Over time the policy will show:

- A. a level death benefit with faster cash accumulation
- B. a rising cash value but an unchanged face amount
- C. a level cash value with an increasing death benefit
- D. both the death benefit and the cash value increasing

2. A policyowner wants permanent coverage but expects to fund it entirely within ten years. The best structure is:

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

3. Which best describes the relationship between premium mode and total annual cost?

- A. Monthly payment reduces the total because amounts are smaller
- B. All modes produce an identical total across the year

- C. More frequent modes increase the total amount paid annually
- D. The mode affects the death benefit rather than the cost

4. An indexed universal life policy credits interest using a participation rate. This means the policy credits:

- A. the full index gain with no upper limit applied
- B. a fixed rate declared annually by the insurer
- C. the index gain only in years the index declines
- D. a stated percentage of the measured index gain

5. The chief practical difference between variable whole life and variable universal life is that variable universal life:

- A. guarantees a minimum interest rate on cash value
- B. permits the owner to vary premium payments
- C. invests exclusively in fixed income subaccounts
- D. requires no securities registration to be sold

6. An insured's term policy is described as level. This means that across the term:

- A. the face amount and the premium both stay constant
- B. the premium rises while the face amount stays constant
- C. the face amount declines while the premium stays constant
- D. both the face amount and the premium decline steadily

7. A survivorship life policy is most often purchased to provide:

- A. income replacement following the first spouse's death
- B. funding for a buy-sell agreement between two partners
- C. liquidity for estate settlement costs at the second death

D. a paid-up policy on a minor child's life at maturity

8. Which statement about a single-premium whole life policy is accurate?

- A. Additional premiums may be paid to raise the face amount
- B. The policy is paid up at issue and builds value immediately
- C. Cash value accumulates more slowly than ordinary whole life
- D. The seven-pay test cannot apply to a single payment

9. An insurer offering an interest-sensitive whole life policy credits cash value at:

- A. current rates, subject to a guaranteed minimum
- B. the performance of separate account subaccounts
- C. a rate tied to an external equity market index
- D. the guaranteed rate only, fixed at policy issue

10. A term policy converted at attained age rather than original age will carry:

- A. a higher initial premium reflecting the earlier age
- B. the same premium as the original term policy
- C. a requirement for new evidence of insurability
- D. a lower initial cost than conversion at original age

11. Which nonforfeiture option is applied automatically where the owner makes no election?

- A. Cash surrender, ending the coverage entirely
- B. Extended term, at the full original face amount
- C. Reduced paid-up, at a smaller face amount
- D. Automatic premium loan against the cash value

12. An owner assigns a policy absolutely to a charity. The charity thereafter holds:

- A. only the right to receive death proceeds when paid
- B. rights limited to the amount of any donation pledged
- C. all ownership rights, including surrender and loans
- D. no rights until the original owner's death occurs

13. A policy provision requiring the insurer to pay only if proof of loss is furnished and premiums are current makes the contract:

- A. aleatory, because values exchanged are unequal
- B. unilateral, because only one party promises
- C. adhesive, because one party drafted the terms
- D. conditional, because performance depends on conditions

14. A premium is thirty days overdue when the insured dies. What does the beneficiary receive?

- A. pay the death benefit less the overdue premium
- B. deny the claim because the policy had lapsed
- C. return all premiums paid and pay no benefit
- D. pay the cash value in place of the face amount

15. Under a per stirpes designation naming three children, one child predeceases the insured leaving two children. Those grandchildren receive:

- A. nothing, as the share passes to surviving children
- B. the entire share of the deceased parent each
- C. the deceased parent's share, divided between them
- D. an equal share alongside the surviving children

16. An accelerated death benefit is most commonly triggered by:

- A. the insured reaching a stated retirement age
- B. the policy reaching its guaranteed maturity date
- C. the insured becoming unemployed for six months
- D. a qualifying terminal or chronic diagnosis

17. The purpose of a common disaster provision is to:

- A. direct proceeds to the contingent beneficiary
- B. divide proceeds between competing claimants
- C. delay payment until an inquest is concluded
- D. void the policy where both parties die together

18. An insurer may contest a life policy after the contestable period has expired where:

- A. the insured misstated their age on the application
- B. no insurable interest existed when the policy issued
- C. the beneficiary designation was later changed
- D. a material medical condition was not disclosed

19. A rider that increases the face amount in line with a published inflation measure is:

- A. a guaranteed insurability rider
- B. a return of premium rider
- C. an accidental death benefit rider
- D. a cost of living rider

20. The waiver of premium rider continues to protect the policyowner:

- A. while the qualifying disability continues in force

- B. for a maximum of two years from the claim date
- C. only until the insured reaches age fifty-nine
- D. only where the disability resulted from accident

21. Which statement about the payor benefit rider is correct?

- A. It waives premiums when the insured child is disabled
- B. It waives premiums if the paying adult dies or is disabled
- C. It transfers policy ownership to the child at majority
- D. It converts the child's coverage to permanent insurance

22. Which is a standard exclusion found in life insurance policies?

- A. Death occurring while the insured is unemployed
- B. Death from a condition disclosed at application
- C. Death while serving in the military during war
- D. Death occurring after the insured turns eighty

23. An applicant submits an application without premium. The insurer issues the policy as applied for. A contract exists when:

- A. the insurer's underwriter approves the application
- B. the policy is printed and mailed to the agent
- C. the policy is delivered and the premium is paid
- D. the applicant signs the original application form

24. An applicant is rated substandard and the insurer issues at an increased premium. This constitutes:

- A. a counteroffer requiring the applicant's acceptance
- B. an acceptance completing the original offer made
- C. a unilateral amendment permitted by the application

D. a rescission of the application previously submitted

25. Which underwriting source may an insurer NOT rely on as the sole basis for declining an applicant?

- A. An attending physician statement from the treating doctor
- B. A coded entry appearing on the MIB report
- C. A paramedical examination conducted for the insurer
- D. An inspection report addressing finances and lifestyle

26. Backdating a policy in order to obtain a lower premium requires the applicant to:

- A. accept a shortened contestable period in exchange
- B. waive the free look period on the delivered policy
- C. provide additional evidence of current insurability
- D. pay the premiums covering the backdated period

27. An agent delivering a policy issued exactly as applied for, with premium already collected, should:

- A. obtain a statement of continued good health first
- B. explain the coverage and obtain a delivery receipt
- C. return the policy for reissue at the current date
- D. collect a second premium to activate the coverage

28. Which is the correct order of the four contract elements as they arise in an insurance transaction?

- A. Consideration, offer, legal purpose, competent parties
- B. Legal purpose, consideration, acceptance, competence
- C. Competent parties, acceptance, offer, consideration
- D. Offer and acceptance, consideration, competence, legal purpose

29. An insured who purchases an annuity is protecting principally against the risk of:

- A. outliving the money accumulated for retirement
- B. dying before dependants become self-supporting
- C. a decline in the value of invested principal
- D. medical costs exceeding available savings

30. A deferred annuity owner takes a free withdrawal permitted by the contract. This means the withdrawal:

- A. is exempt from income taxation entirely
- B. reduces the death benefit but not the account
- C. incurs no surrender charge from the insurer
- D. may be repaid to restore the original value

31. An annuitant selecting joint and full survivor rather than life only will receive:

- A. a larger periodic payment for the same purchase amount
- B. the same payment, with a benefit added at no cost
- C. payments guaranteed for a minimum of twenty years
- D. a smaller periodic payment for the same purchase amount

32. Which annuity is funded by a single payment and begins paying within one payment interval?

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

33. A section 457 deferred compensation plan is available to:

- A. state and local government employees
- B. employees of for-profit corporations only
- C. public school teachers exclusively
- D. self-employed persons without employees

34. An employee contributes to a Roth arrangement. Qualified distributions later received are:

- A. fully taxable as ordinary income when received
- B. taxable only on the growth above contributions
- C. received free of federal income tax entirely
- D. taxed as capital gain at the recipient's rate

35. The exclusion ratio applied to a nonqualified annuity is calculated as:

- A. the annual payment divided by the account value
- B. the expected return divided by the investment
- C. the taxable gain divided by the total payments
- D. the investment in the contract divided by expected return

36. A worker is currently insured but not fully insured under Social Security. The worker's family is eligible for:

- A. a narrower set of survivor benefits only
- B. the full range of retirement benefits available
- C. no benefits of any description whatsoever
- D. disability benefits but not survivor benefits

37. Which arrangement uses life insurance owned by the business to purchase a deceased owner's interest?

- A. A cross-purchase arrangement between the owners
- B. A key person arrangement compensating for loss
- C. An entity or stock redemption arrangement
- D. A split dollar arrangement sharing premium cost

38. Death proceeds paid in a lump sum are generally free of income tax, but may still be:

- A. subject to state premium tax on the amount paid
- B. included in the insured's taxable estate
- C. reduced by the insurer's administrative charges
- D. taxed as capital gain in the beneficiary's hands

39. A Modified Endowment Contract owner takes a policy loan before age fifty-nine and a half. The loan is:

- A. treated as a tax-free return of basis first
- B. exempt from tax as a loan rather than a distribution
- C. taxable only on amounts above total premiums paid
- D. taxed gain first, and may attract an additional penalty

40. Which best describes the human life value approach compared with the needs approach?

- A. It totals specific obligations then deducts resources
- B. It applies a fixed multiple to current annual income
- C. It values the insured's future earnings as an asset
- D. It sizes coverage to the client's premium budget

41. An applicant tells the agent about a medication for high blood pressure. The agent must:

- A. record it accurately on the application submitted
- B. omit it unless the insurer specifically asks

- C. note it only in the separate agent's report
- D. advise the applicant to disclose it at delivery

42. Which is the strongest reason an agent should refuse to submit a knowingly misrepresented application?

- A. The insurer will reduce the commission payable
- B. Submitting it participates in the misrepresentation
- C. The applicant will be charged a higher premium
- D. The underwriting department will detect it anyway

43. A binding receipt provides coverage:

- A. only where the applicant proves insurable as standard
- B. from the date the policy is finally delivered
- C. from the receipt date for a stated period regardless of insurability
- D. only after the required medical examination is completed

44. An applicant is rated because of something a reporting agency told the insurer. What is owed to that applicant?

- A. a free copy of the complete report on request
- B. reimbursement of the reporting agency's fee
- C. an alternative offer of coverage at a rated premium
- D. notice of the decline and the agency's identity

45. Which risk classification reflects average expected mortality?

- A. Preferred, showing better than average health
- B. Standard, reflecting the average expected experience
- C. Substandard, carrying higher expected mortality

D. Declined, reflecting an unacceptable level of risk

46. An impairment rider differs from a rating because the rider:

- A. excludes a named condition rather than raising the premium
- B. applies only during the policy's contestable period
- C. may be removed at the policyowner's later request
- D. increases the premium while covering all conditions

47. An insured's disability policy defines disability by loss of income rather than loss of duties. This is:

- A. an any occupation definition applied after two years
- B. a presumptive disability provision on catastrophic loss
- C. an own occupation definition applied from the outset
- D. an income replacement definition of disability

48. A probationary period in a disability policy typically covers accidents:

- A. only after the period has fully elapsed
- B. at half the benefit during the period
- C. from the first day the policy takes effect
- D. only where the accident occurs at the workplace

49. An insured returns to work at reduced earnings under a residual disability provision. The benefit payable is:

- A. proportionate to the percentage of income lost
- B. one half of the full monthly benefit amount
- C. the full benefit until earnings fully recover
- D. nothing, because the insured has returned to work

50. Business overhead expense coverage typically provides a benefit period of:

- A. the insured owner's remaining working lifetime
- B. one to two years, bridging a temporary gap
- C. five years from the onset of the disability
- D. until the business is sold or wound up

51. A disability buy-sell policy differs from business overhead expense because it:

- A. reimburses continuing operating costs of the business
- B. replaces the disabled owner's regular salary or draw
- C. funds the purchase of the disabled owner's interest
- D. pays the business for recruiting a replacement worker

52. Under an accidental death and dismemberment policy, benefits are typically payable only where the loss occurs:

- A. while the insured is at the place of employment
- B. during the first two years of the policy term
- C. outside the insured's state of permanent residence
- D. within a stated period following the accident

53. A member's plan applies a \$2,000 deductible and 70/30 coinsurance with no out-of-pocket maximum reached. On \$12,000 of covered charges the member pays:

- A. \$5,000, being the deductible plus thirty percent
- B. \$3,600, being thirty percent of the total charges
- C. \$2,000, being the annual deductible amount only
- D. \$3,000, being thirty percent after the deductible

54. A managed care plan requiring approval before a scheduled surgery is applying:

- A. concurrent review during the course of treatment
- B. precertification, sometimes called prior authorization
- C. retrospective review after care is delivered
- D. capitation, paying providers a fixed monthly sum

55. A staff model HMO is distinguished by physicians who are:

- A. organized into a single large multi-specialty group
- B. contracted individually while keeping private practices
- C. drawn from several separately contracted groups
- D. employed directly and salaried by the organization

56. An HMO member obtaining emergency care outside the service area will find that care:

- A. is excluded because the provider is out of network
- B. is covered only after retroactive authorization
- C. is covered, because emergencies are an exception
- D. is reimbursed at half the in-network benefit level

57. A flexible spending account differs from a health savings account because the flexible spending account:

- A. is generally forfeited if unused at year end
- B. requires enrollment in a high deductible plan
- C. belongs to the individual and travels between jobs
- D. permits balances to roll over indefinitely

58. Long-term care insurance exists principally because neither Medicare nor major medical covers:

- A. skilled nursing following a qualifying hospital stay
- B. custodial care assisting with daily living
- C. physician services delivered in an office setting
- D. prescription drugs dispensed on an outpatient basis

59. Which activity is NOT among the six activities of daily living used as a long-term care benefit trigger?

- A. Transferring between a bed and a chair
- B. Bathing and maintaining personal hygiene
- C. Toileting and maintaining continence
- D. Managing personal finances and paying bills

60. A Medicare supplement policy's standardization by letter means that:

- A. the same letter provides identical core benefits everywhere
- B. premiums for a given letter are identical between insurers
- C. each state designs its own lettered benefit packages
- D. insurers may add extra benefits to a lettered plan

61. COBRA continuation extends to twenty-nine months where:

- A. the qualifying event is the employee's death
- B. a dependent child ceases to qualify as a dependent
- C. a disability determination applies during continuation
- D. the employer terminates its group health plan

62. A contributory group health plan ordinarily requires participation of approximately:

- A. one hundred percent of eligible employees
- B. seventy-five percent of eligible employees

- C. fifty percent of eligible employees
- D. twenty-five percent of eligible employees

63. A hospital indemnity policy is characterized by payment that is:

- A. limited to charges the plan considers customary
- B. coordinated with the member's major medical plan
- C. a fixed amount per day regardless of charges
- D. available only after a deductible has been satisfied

64. A dental plan's major services category typically includes:

- A. crowns and bridges, paid at a lower percentage
- B. routine cleanings, paid at or near full value
- C. fillings and extractions, paid at a middle rate
- D. orthodontia, always covered without any maximum

65. An insured must furnish proof of loss under the uniform provisions within:

- A. twenty days after the loss first occurs
- B. fifteen days after the insurer supplies forms
- C. sixty days after the insurer requests it
- D. ninety days after the loss or benefit period ends

66. Which mandatory provision protects an insured whose policy lapsed but who wishes to restore it?

- A. Grace period, permitting late payment in force
- B. Reinstatement, governing restoration after lapse
- C. Time limit on certain defenses, barring contest
- D. Legal actions, bounding the period to sue

67. An optional provision permitting the insurer to limit total coverage where the insured holds several policies with the same company is:

- A. relation of earnings to insurance, reducing benefits
- B. other insurance in this insurer, refunding excess premium
- C. change of occupation, adjusting the benefit payable
- D. illegal occupation, excluding certain circumstances

68. An insured changes to a less hazardous occupation and notifies the insurer. The insured is entitled to:

- A. a refund of unearned premium at the lower rate
- B. an increase in the benefit amount payable
- C. a shortened elimination period on future claims
- D. cancellation of the policy with full premium returned

69. Which renewability classification permits the insurer to decline renewal only at stated renewal dates?

- A. Noncancelable, guaranteeing renewal and premium
- B. Guaranteed renewable, permitting class increases
- C. Cancelable, permitting termination at any time
- D. Optionally renewable, permitting decline at renewal

70. A guaranteed insurability rider on a disability policy is usually described as:

- A. a presumptive disability provision on catastrophic loss
- B. a recurrent disability provision covering relapse
- C. a future increase option, financially underwritten
- D. a social insurance supplement coordinating benefits

71. An insured relapses from the same condition four months after returning to work, under a recurrent disability provision with a six month period. The insured:

- A. must satisfy a new elimination period first
- B. resumes benefits without a new elimination period
- C. begins an entirely new benefit period of full length
- D. receives half the benefit for the second episode

72. Which product may still lawfully impose a preexisting condition exclusion?

- A. An individual disability income policy
- B. An individual major medical Marketplace plan
- C. A small group comprehensive medical plan
- D. A large employer group major medical plan

73. Medicare Part A skilled nursing coverage requires:

- A. enrollment in a Medicare Advantage plan first
- B. a physician certifying permanent custodial need
- C. purchase of a Medicare supplement policy
- D. a qualifying prior inpatient hospital stay

74. A beneficiary of a Medicare Advantage plan who wishes to buy a Medigap policy should be told that:

- A. both may be held provided premiums are paid
- B. the Medigap policy will pay before Advantage
- C. the Advantage plan must be converted first
- D. a Medigap policy cannot function alongside Advantage

75. A dual eligible beneficiary receives payment from Medicaid:

- A. before Medicare, as the primary payer
- B. instead of Medicare, replacing that coverage
- C. after Medicare, for services and cost sharing
- D. only where Medicare has denied the claim

76. The Social Security disability definition is closest in effect to which private definition?

- A. Own occupation, applied for an initial period
- B. Income replacement, proportionate to earnings
- C. Any occupation, requiring inability to work at all
- D. Residual disability, paying on partial income loss

77. A person covered under their own employer plan and as a dependent under a spouse's plan finds that:

- A. the spouse's plan pays first for that person
- B. their own employer plan is primary for them
- C. the plans split every claim equally between them
- D. the person must elect one plan and drop the other

78. Under standard coordination of benefits, the secondary plan may pay:

- A. the balance the primary left, up to its own limits
- B. only the excess over what the primary actually paid
- C. the full claim amount without regard to the primary
- D. nothing, since the primary has already responded

79. Workers compensation income benefits are commonly paid retroactively to the date of injury where:

- A. the disability continues beyond a stated longer period

- B. the employer failed to report the injury promptly
- C. the worker files suit against a responsible third party
- D. the injury occurred outside normal working hours

80. An agent who observes an applicant's home is in serious disrepair during a visit should:

- A. decline the application on that basis alone
- B. disregard it as irrelevant to a life application
- C. discuss it with the applicant before submitting
- D. note it in the agent's report to the insurer

81. Which action would constitute forgery by an agent?

- A. Recording the applicant's answers on the form
- B. Initialing a correction the applicant approved verbally
- C. Signing the applicant's name with verbal permission
- D. Signing the agent's own name on the application

82. Under the USA PATRIOT Act framework, an agent selling annuities must:

- A. verify the source of every premium payment received
- B. receive training and report suspicious activity
- C. obtain federal registration before selling contracts
- D. file a report on every transaction above a threshold

83. An investigative consumer report differs from an ordinary consumer report because it:

- A. is obtained only after coverage has been declined
- B. is exempt from the Fair Credit Reporting Act
- C. reports only medical findings from physicians
- D. gathers information through personal interviews

84. Using the insurer's own forms and displaying its name at an office are examples of which authority?

- A. binding coverage on a substandard applicant
- B. acts reasonably necessary to exercise express powers
- C. waiving a policy provision at the client's request
- D. amending an application after it has been submitted

85. A client asks the agent to reduce the premium by contributing part of the commission. The agent should:

- A. agree, since the client requested the arrangement
- B. agree, provided the insurer is notified in writing
- C. decline, because rebating is prohibited regardless
- D. decline only if the amount exceeds a nominal value

86. Which situation clearly constitutes replacement requiring the prescribed notices?

- A. An existing policy is allowed to lapse to fund the new premium
- B. A new rider is added to an existing in-force policy
- C. An existing policy is assigned to a bank as collateral
- D. A beneficiary designation on an existing policy is changed

87. Churning is best distinguished from twisting because churning:

- A. generates replacement business without client benefit
- B. induces replacement through false statements
- C. involves sharing commission with the policyholder
- D. conceals a material fact from the insurer's underwriter

88. An agent presents a comparison omitting that the new policy restarts the contestable period. This omission:

- A. is acceptable because the period is stated in the policy
- B. is acceptable where the client did not ask about it
- C. affects only the insurer, not the client's interests
- D. makes the comparison incomplete and constitutes twisting

89. Premium funds an agent holds before transmitting them to the insurer are held:

- A. as the agent's own property until earned
- B. as a loan repayable to the applicant on demand
- C. in a fiduciary capacity for the insurer
- D. in trust for the state insurance department

90. An insurer issues a policy on an application where the applicant left the tobacco use question blank. The insurer has generally:

- A. grounds to rescind within the contestable period
- B. waived that question and cannot rely on the omission
- C. the right to reclassify the risk at any later date
- D. an obligation to refund the premiums collected

91. Which underwriting practice would violate the prohibition on unfair discrimination?

- A. Charging a smoker more than a nonsmoker of the same age
- B. Declining an applicant with a serious untreated condition
- C. Charging two identical risks materially different premiums
- D. Rating an applicant whose stated occupation is hazardous

92. An agent's statement that a competitor is close to insolvency, made without foundation, constitutes:

- A. rebating, by conferring an unlawful inducement
- B. defamation, harming an insurer's reputation falsely
- C. commingling, involving the misuse of funds
- D. coercion, restraining the business of insurance

93. An applicant asks whether an illustration's projected values are guaranteed. The agent must explain that:

- A. guaranteed and non-guaranteed elements are separately shown
- B. all illustrated values are guaranteed by the insurer
- C. projections become guaranteed after the first five years
- D. the insurer will match the projection or refund premiums

94. Which best states the agent's obligation regarding an applicant's confidential information?

- A. It may be shared with other clients as examples
- B. It becomes the agent's property upon policy issue
- C. It must be filed with the state insurance department
- D. It is protected by federal privacy requirements

95. Which pair of facts together most strongly indicates a stranger-originated arrangement?

- A. Third-party premium funding and planned early ownership transfer
- B. A large face amount and a preferred underwriting class
- C. An older applicant and a level premium whole life policy
- D. A business owner and a policy funding a buy-sell agreement

96. An agent who cannot produce records of a transaction when the Department asks is:

- A. protected, since the insurer retains its own copies
- B. excused where the transaction predates the request
- C. poorly placed to answer a complaint about it
- D. automatically presumed to have acted fraudulently

97. Which best describes the effect of the entire contract provision on oral statements made at the sale?

- A. They bind the insurer if the agent recorded them
- B. They form no part of the agreement between the parties
- C. They override the written policy where they conflict
- D. They become binding once the policy is delivered

98. A statement of continued good health is NOT required where:

- A. the applicant's health changed during underwriting
- B. the policy was issued at a substandard rating
- C. the policy was delivered more than thirty days late
- D. the initial premium accompanied the application

99. An agent may lawfully receive commission on business produced by:

- A. an unlicensed assistant who completed the paperwork
- B. a friend who referred the client for a share
- C. any person, provided the client consents in writing
- D. a person licensed at the time of the transaction

100. An applicant under the influence of alcohol signs an application. The contract element in question is:

- A. competent parties, since capacity is impaired
- B. legal purpose, since the object may be unlawful

- C. consideration, since nothing of value was given
- D. offer and acceptance, since no offer was made

101. A Texas licensee completes twenty-four continuing education hours entirely by self-study. This satisfies:

- A. the requirement in full, as hours are hours
- B. the requirement provided three hours were ethics
- C. neither, because at least twelve must be classroom
- D. the requirement only for a first renewal period

102. A Texas agent license expired sixty days ago and the licensee wishes to continue working. The licensee must:

- A. apply for a new license and retake the examination
- B. renew late, paying an additional fee with the renewal
- C. file for reinstatement without paying any fee
- D. cease all activity until the next renewal cycle opens

103. Which is required of a Texas license applicant before the license is issued?

- A. Completion of a bachelor's degree in any field
- B. Residence in Texas for at least twelve months
- C. Submission of fingerprints for criminal history checks
- D. Sponsorship by a currently appointed Texas agent

104. A temporary Texas licensee wishes to add a second company appointment. This is:

- A. not permitted while the temporary license is in force
- B. permitted on payment of the additional appointment fee
- C. permitted only where the sponsoring company consents

D. permitted after thirty days of the temporary period

105. Which best describes the Commissioner's rulemaking power?

- A. The Commissioner enacts statutes governing insurance
- B. The Commissioner adopts rules enforcing the Insurance Code
- C. The Commissioner amends the Insurance Code directly
- D. The Commissioner repeals statutes that are obsolete

106. A Texas insurer's classification as domestic, foreign, or alien depends on:

- A. where the insurer maintains its largest office
- B. the number of Texas policyholders it serves
- C. whether it writes life or health lines of business
- D. where the insurer was organized under law

107. A Texas agent transacts business for an insurer that has not filed an appointment. This is:

- A. a violation, because appointment precedes selling
- B. permitted where the agent holds a valid license
- C. permitted for ninety days pending the filing
- D. a matter between insurer and agent only

108. The Guaranty Association annuity limit is expressed as:

- A. \$100,000 in accumulated account value
- B. \$300,000 in total payments received
- C. \$500,000 in contract value at insolvency
- D. \$250,000 in present value per individual life

109. Which practice is prohibited under Texas rules governing prohibited trade practices?

- A. Recommending a policy issued by a competing insurer
- B. Restraining the business of insurance through coercion
- C. Explaining that policy dividends are not guaranteed
- D. Declining to write business the agent considers unsuitable

110. An agent's failure to report an administrative action taken by another state is:

- A. excused where the action was later reversed
- B. reportable only at the next license renewal
- C. itself a ground for disciplinary action in Texas
- D. a matter for the other state's regulator alone

111. Under Texas law, an insurer may include in a life policy an interest charge on premium unpaid during the grace period if:

- A. the rate of interest is specified in the policy
- B. the policyowner consents in writing at issue
- C. the Commissioner approves the rate separately
- D. the grace period exceeds thirty-one days in length

112. Eighteen months after issue, an insurer discovers the insured concealed a diagnosis. In Texas the insurer may:

- A. incontestable, because eighteen months exceeds one year
- B. still contestable for material misstatements in the application
- C. contestable only for nonpayment of the premium due
- D. incontestable except for military service in wartime

113. A Texas life insurer refuses a policy loan on a term policy with an incidental cash value. This is:

- A. a violation, since cash value exists in the contract
- B. a violation, unless three years of premiums are unpaid
- C. permitted, because term policies need not offer loans
- D. permitted only where the policy is nonparticipating

114. The Buyer's Guide a Texas prospect receives is intended to:

- A. disclose the agent's commission on the transaction
- B. summarize the insurer's audited financial position
- C. list every policy form the insurer has approved
- D. explain life insurance in general terms to the buyer

115. An agent produces a modified version of an insurer's illustration showing lower projected values. This is:

- A. prohibited, because the illustration is the insurer's representation
- B. permitted, because conservative figures protect the client
- C. permitted where the agent signs and dates the change
- D. prohibited only where the modification raises values

116. Under Texas replacement rules, the replacing agent must obtain:

- A. the existing insurer's written consent to proceed
- B. the applicant's signature on the replacement notice
- C. a surrender form signed by the existing beneficiary
- D. Departmental approval before submitting the application

117. Conservation in a Texas replacement transaction refers to the opportunity for:

- A. the replacing insurer to withdraw its offer
- B. the Department to review the transaction
- C. the agent to retain the replacement commission
- D. the existing insurer to communicate with its policyholder

118. The Texas Standard Nonforfeiture Law prescribes values that an insurer may:

- A. reduce where investment results are unfavourable
- B. waive with the policyowner's written agreement
- C. exceed but never fall below in any policy
- D. apply only after ten policy years have elapsed

119. A Texas group life certificate holder converting after employment ends receives a policy priced at:

- A. the original group rate then in effect
- B. the member's attained age at conversion
- C. the age the member first joined the group
- D. a standard rate set annually by the Department

120. How large may a Texas credit life policy be in relation to the debt it secures?

- A. must equal twice the outstanding loan balance
- B. is set by the creditor without any statutory limit
- C. remains level throughout the loan's full term
- D. may not exceed the amount of the indebtedness

121. A Texas health plan covering a newborn may require the parent to:

- A. notify the carrier and pay any additional premium
- B. complete a medical questionnaire on the child
- C. enroll the child before the birth takes place

D. accept a waiting period before coverage begins

122. A Texas Medicare supplement insurer may cancel a policy where the insured:

- A. develops a costly and chronic medical condition
- B. submits an unusually high number of valid claims
- C. has materially misrepresented a fact at application
- D. reaches an advanced age stated in the contract

123. Having lawfully obtained a positive HIV result, a Texas insurer may:

- A. infer the applicant's sexual orientation for rating
- B. make an underwriting decision on medical evidence
- C. notify the applicant's employer of the finding
- D. decline the applicant without any notification

124. The Texas small employer band applies to employers with:

- A. two to fifty eligible employees
- B. one to twenty-five eligible employees
- C. five to one hundred eligible employees
- D. ten to seventy-five eligible employees

125. Before ceasing to write small employer coverage in Texas, a carrier is obliged to:

- A. obtain the Commissioner's prior written approval
- B. transfer its block to a willing successor carrier
- C. continue renewing existing groups for five years
- D. give advance notice and accept a re-entry bar

126. A Texas consumer purchasing a Marketplace plan obtains coverage through:

- A. a state exchange operated by the Department
- B. a regional exchange shared with adjacent states
- C. the federally facilitated Marketplace
- D. a private exchange run by participating carriers

127. An employee eligible for a premium tax credit may take it:

- A. only as a lump sum refund after the plan year ends
- B. in advance against monthly premiums, or at filing
- C. only where the employer contributes nothing at all
- D. only in combination with a cost-sharing reduction

128. Texas rules require that an HMO's evidence of coverage be:

- A. filed annually with the Secretary of State
- B. renewed by each enrollee every twelve months
- C. identical in wording to a standard state form
- D. approved by the Department before it is used

129. An HMO enrollee treated by an out-of-network anaesthetist at an in-network hospital is protected because:

- A. all hospital-based providers are deemed in network
- B. the HMO must retroactively contract with that provider
- C. the enrollee had no meaningful opportunity to choose
- D. the enrollee obtained a referral from the gatekeeper

130. Which is a legitimate ground for a Texas HMO to refuse renewal of an enrollee's coverage?

- A. Nonpayment of the premium due under the contract
- B. The enrollee's diagnosis with a chronic illness
- C. The volume of covered services the enrollee used
- D. A complaint the enrollee filed with the Department

Practice Exam 5: Answer Key and Explanations

1. **D** — Paid-up additions apply each dividend as a single premium to purchase small, fully paid-up increments of permanent coverage. Because each increment is itself insurance with its own value, both the total death benefit and the total cash value grow. Cash, premium reduction, and accumulation at interest do none of that.
2. **C** — Limited-pay whole life compresses the full lifetime cost into a shorter payment window, so a ten-pay policy is fully paid after ten years while coverage continues for life with nothing further due. Ordinary whole life requires premiums to maturity, term provides no permanence, and universal life guarantees no paid-up date.
3. **C** — The more frequently premiums are paid, the greater the total outlay across a year, because the insurer loses investment earnings on money received later and incurs additional administrative expense. Annual payment is always cheapest in total. Candidates reasoning that smaller payments must be cheaper overall consistently answer this incorrectly. Annual payment is always cheapest in total.
4. **D** — A participation rate credits a stated percentage of the measured index gain rather than the whole of it, and a cap may separately limit the maximum credited. In exchange the contract guarantees a floor, commonly zero, so a falling index cannot reduce account value through the crediting mechanism itself. A cap may separately limit the credited gain.
5. **B** — Variable whole life keeps a fixed premium and a guaranteed minimum death benefit while cash value fluctuates. Variable universal life adds universal life's flexible premium, producing the least guaranteed product in common use. Both place cash value in separate accounts, both are securities, and both require a securities registration to sell.
6. **A** — Level term holds both the face amount and the premium constant for the full period, and it is the most commonly sold term form. Annually renewable term raises the premium each year with attained age, and decreasing term reduces the death benefit on a schedule while holding the premium level.
7. **C** — Survivorship life pays only when the second insured dies, which matches when estate settlement costs actually fall due for a married couple. Income replacement and buy-sell funding both arise at a first death and call for joint life instead, and a juvenile policy addresses an entirely different objective. Timing of the need selects the product.

8. B — A single lump sum purchases a fully paid-up policy at issue, producing substantial cash value immediately rather than gradually. Because the payment almost always exceeds the seven-pay limit, the contract is nearly always a Modified Endowment Contract, which alters the tax treatment of lifetime distributions but never the death benefit.

9. A — Interest-sensitive whole life, also called current assumption whole life, keeps the fixed premium and structure of traditional whole life but credits current interest rates rather than only the guaranteed rate. It offers no premium flexibility and uses no separate accounts, which distinguishes it from universal and variable products respectively. No separate accounts are involved at all.

10. D — Conversion at attained age prices the permanent policy using the insured's current age, which costs less at the moment of conversion than backdating to the original age. Neither method requires new evidence of insurability, which is the whole value of convertibility to an insured whose health has since declined. Convertibility protects an insured whose health declined.

11. B — Extended term is ordinarily the automatic option applied when the owner makes no election, keeping the full original face amount as term insurance for as long as the cash value will fund. Reduced paid-up must generally be elected, and cash surrender requires an affirmative request from the policyowner. Election is required to obtain the alternatives.

12. C — An absolute assignment transfers all ownership rights permanently to the assignee, who may then name beneficiaries, borrow against cash value, or surrender the contract. A collateral assignment transfers rights only to the extent of a debt and ends when that debt is satisfied, leaving the balance with the owner. Beneficiaries may then be renamed by the assignee.

13. D — A conditional contract obliges the insurer to perform only where stated conditions are satisfied, such as furnishing proof of loss and keeping premiums current. Aleatory describes the unequal exchange of value, unilateral describes only one enforceable promise, and adhesion describes a contract drafted entirely by the insurer. Each characteristic carries its own practical consequence.

14. A — The policy remains in full force throughout the grace period, so the death benefit is payable in the ordinary way, with the overdue premium deducted from the proceeds. Lapse occurs only where the grace period expires without payment, and only then does the coverage end for nonpayment of premium. Lapse follows only where the period expires unpaid.

15. C — Per stirpes means by the branch, so a deceased beneficiary's share passes to that beneficiary's own descendants and is divided among them. Here the deceased child's third is split between the two grandchildren, giving each a sixth. Per capita would instead redistribute that share among the surviving named children. The branch rather than the head governs distribution.

16. D — Accelerated death benefits pay part of the death benefit during life on a qualifying diagnosis, typically terminal illness or a chronic condition meeting stated criteria. The amount advanced reduces what the beneficiary later receives and may affect eligibility for needs-based public benefits, and both consequences require clear disclosure. Disclosure of both consequences is therefore essential.

17. A — Where the insured and the beneficiary die in the same event and the order of death cannot be established, the provision presumes the insured survived, so proceeds pass to the contingent beneficiary rather than through the beneficiary's estate. That result protects the policyowner's evident intention in naming a contingent beneficiary.

18. B — Incontestability bars contest for application misstatements after the stated period, but matters going to whether a valid contract ever existed sit outside that protection, including absence of insurable interest and impersonation at a medical examination. Misstatement of age is corrected proportionally rather than being a ground for contest. Those matters concern whether a contract existed.

19. D — A cost of living rider raises the face amount against a stated inflation measure so the death benefit retains purchasing power, with additional premium charged as the amount increases. Guaranteed insurability permits future purchases without underwriting, and return of premium refunds premiums under stated conditions rather than indexing coverage. Additional premium accompanies each face amount increase.

20. A — Waiver of premium relieves the owner of premium payments while a qualifying total disability continues, after the rider's own waiting period, with coverage remaining in full force throughout. It responds to disability from sickness as well as accident, and its duration follows the disability rather than a fixed two year cap.

21. B — The payor benefit applies where an adult owns and pays for a policy on a child's life, waiving premiums until the child reaches a stated age if the paying adult dies or becomes disabled. It protects the child's coverage against loss of the person funding it rather than responding to the child's own health.

22. C — Conventional life exclusions cover war or military service, aviation other than as a fare-paying passenger on a scheduled flight, and undisclosed hazardous occupations or avocations. A condition disclosed at application is underwritten rather than excluded, and neither employment status nor advanced age operates as an exclusion. Aviation exclusions operate on a similar principle.

23. C — Where no premium accompanied the application, the insurer's issue is an acceptance but coverage attaches only on delivery in good health with the initial premium collected. Approval, printing, and the applicant's signature all precede that moment, and none of them by itself brings the contract into force. Good health at delivery remains a condition.

24. A — Acceptance must match the offer. A policy issued at a rated premium differs from what was applied for, so it is a counteroffer the applicant must accept, which occurs by paying the modified premium and taking delivery. Only at that point does a binding contract come into existence between them.

25. B — 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 an MIB code. The other sources produce substantive findings the insurer may act upon. It signals where to investigate rather than deciding.

26. D — Backdating dates the policy earlier so the premium is calculated at a lower insurance age, and the applicant must pay the premiums covering the backdated period. Coverage is never provided retroactively, so a death during that period is not covered whatever date appears on the policy document itself. A death in that period is not covered.

27. B — Where premium accompanied the application, coverage already attached under the receipt, so no statement of continued good health is required. The agent explains the death benefit, premium, riders, and exclusions, and obtains a signed delivery receipt recording the date, because the free look ordinarily runs from delivery. The free look ordinarily runs from delivery.

28. D — All four elements must be present for an enforceable contract, and the conventional statement lists offer and acceptance, consideration, competent parties, and legal purpose. The applicant offers by submitting the application with premium, and the insurer accepts by issuing the policy as applied for rather than on modified terms. A rated policy is a counteroffer rather than acceptance.

29. A — An annuity liquidates a sum across an uncertain lifetime, guaranteeing income for as long as the annuitant lives, so it addresses longevity risk. Life insurance addresses the opposite exposure of dying too soon. Only an insurer can make the lifetime promise, because only an insurer pools longevity across many lives.

30. C — Most deferred annuity contracts permit a free withdrawal of a stated percentage annually without a surrender charge. The withdrawal remains taxable on a gain-first basis before annuitization, permanently reduces the account value, and cannot be repaid. Free refers only to the absence of the insurer's surrender charge. Taxation and account reduction are unaffected by it.

31. D — Every guarantee added for a survivor reduces the periodic payment, because the insurer has assumed a longer expected obligation. Joint and full survivor continues the same amount to the second annuitant for life, which is the most expensive survivor arrangement and therefore produces the smallest initial payment. Longer expected obligations always reduce the payment.

32. B — An immediate annuity begins paying within one payment interval of purchase and must therefore be funded by a single premium, since payments cannot start while funding continues. Flexible premium funding is available only with deferred annuities, and the flexible premium immediate combination simply cannot exist at all. Funding must be complete before payments begin.

33. A — Section 457 plans serve state and local government employees and carry their own distribution rules. Section 401(k) arrangements serve employees of for-profit employers, section 403(b) plans serve public school and certain nonprofit employees, and Keogh plans cover owner-employees of unincorporated businesses instead. Employer type is the deciding clue in these questions.

34. C — 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 inverts the ordinary qualified plan trade by paying tax at the front end rather than at the point of distribution. Tax is paid at the front rather than the back.

35. D — The exclusion ratio divides the investment in the contract by the expected total return, producing the proportion of each payment excluded from tax as a return of basis. The remainder is taxable gain. Once basis has been fully recovered, later payments become entirely taxable because nothing remains to exclude. Expected return depends on the payment and life expectancy.

36. A — Currently insured status requires six quarters of coverage within the preceding thirteen and confers a narrower set of survivor benefits than fully insured status. Forty quarters make a worker permanently fully insured for retirement benefits, and quarters are credited on earnings with a maximum of four in any calendar year.

37. C — Under an entity or stock redemption arrangement the business owns the policies and buys the deceased owner's interest itself, requiring one policy per owner. Cross-purchase has each owner insure the others personally, and key person insurance compensates the firm for a loss rather than funding any purchase of ownership. Policies required grow rapidly under cross-purchase.

38. B — Income-tax-free does not mean estate-tax-free. Proceeds may be included in the insured's taxable estate where the insured held incidents of ownership at death, which is a separate question from income taxation and a frequent source of confusion for clients and candidates alike. Incidents of ownership are what create that inclusion.

39. D — Modified Endowment Contract treatment reverses the ordinary ordering, so withdrawals and policy loans are taxed on a gain-first basis rather than a return-of-basis-first basis, and distributions before a stated age may carry an additional penalty. The death benefit alone remains generally income-tax-free to the beneficiary. Loans and withdrawals are treated identically here.

40. C — Human life value treats the insured as an economic asset and calculates the present value of future earnings that would have supported the family. The needs approach instead totals specific obligations such as final expenses, debt, income replacement, and education, then subtracts existing resources already available to the family. Identified obligations make the needs approach dominant.

41. A — Field underwriting requires the agent to record the applicant's answers accurately, because information given to the agent is imputed to the insurer. An agent who decides a disclosed condition is too minor to record creates a misrepresentation the insurer will struggle to enforce and a professional liability for themselves. Knowledge given the agent is imputed to the insurer.

42. B — An agent who knows an application misstates a material fact and submits it anyway has participated in the misrepresentation, exposing the agent to disciplinary action independent of anything the insurer does. Commission, premium, and the likelihood of detection are practical considerations rather than the governing professional reason. Disciplinary exposure attaches to the agent personally.

43. C — A binding receipt places the insurer on risk from the date of the receipt for a stated period, whether or not the applicant would ultimately have qualified, until the insurer issues or declines. A conditional receipt instead attaches coverage only where the applicant proves insurable as a standard risk. Insurability is the condition distinguishing the two receipts.

44. D — The Act requires that an applicant declined or rated because of report information be told and given the reporting agency's identity, so the information can be disputed and corrected. It does not require the insurer to supply the report itself, reimburse any cost, or offer alternative coverage instead. Disputing wrong information is the Act's real purpose.

45. B — Standard risks represent average expected mortality and pay the ordinary rate. Preferred risks show better than average health and habits and receive the lowest rate, substandard risks pay more or accept restrictions, and declined applicants are those the insurer will not accept at any premium whatsoever. Classification lets the law of large numbers work.

46. A — An impairment or exclusion rider removes coverage for one named condition while the rest of the policy remains intact, whereas a rating charges a higher premium while covering everything. Both are alternatives to declining an applicant, and a condition excluded by name at issue remains excluded permanently. Named exclusions at issue remain permanent afterward.

47. D — An income replacement definition measures disability by earnings lost 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.

48. C — The probationary period runs from the policy's effective date and bars sickness beginning during it, because an illness may have been developing before purchase. Accidents are ordinarily covered from day one, since an accident cannot have been incubating, and location of the accident is irrelevant to that rule. An accident cannot have been incubating beforehand.

49. A — Residual disability measures loss of income rather than loss of duties and pays in proportion to that loss, so an insured earning seventy percent of prior income receives thirty percent of the full benefit. This removes the financial penalty for attempting a partial return that a strict total disability contract imposes.

50. B — Benefit periods for business overhead expense are short, typically one to two years, because the policy exists to bridge a gap rather than fund an indefinite absence. Premiums are deductible as a business expense and the benefits are correspondingly taxable to the business receiving them. Premiums are deductible and benefits correspondingly taxable.

51. C — A disability buy-sell funds the purchase of a disabled owner's interest under a prior agreement, in the way life insurance funds a purchase on death. Business overhead expense reimburses continuing operating costs, and key employee disability compensates the firm for the absence of a person whose contribution is measurable. Each coverage answers a different business need.

52. D — Benefits are ordinarily payable only where death or dismemberment occurs within a stated period after the accident, commonly ninety days, which establishes the causal link between the two events. Standard exclusions include suicide, self-inflicted injury, war, and injury sustained while committing a felony. Causation between accident and loss must be shown.

53. A — The member pays the \$2,000 deductible first, leaving \$10,000 subject to coinsurance. Thirty percent of \$10,000 is \$3,000, so the member's total is \$5,000 and the plan pays \$7,000. Applying coinsurance to the full charge before subtracting the deductible is the error the distractors are built around. Order of operations decides these calculations.

54. B — Precertification, also called prior authorization, applies before treatment is delivered. Concurrent review applies during a hospital stay, and retrospective review applies afterward. A member who fails to obtain required precertification ordinarily faces a reduced benefit rather than outright denial of an otherwise covered claim. Reduced benefit rather than denial is the usual penalty.

55. D — A staff model employs physicians directly on salary. A group model contracts with one large multi-specialty group, an independent practice association contracts with physicians who keep their own private practices, and a network model contracts with several groups, each arrangement offering members a different degree of choice. Member choice differs across the four models.

56. C — An HMO generally covers nothing obtained outside its network, but emergency care is the recognized exception because an enrollee facing an emergency has no meaningful opportunity to select a participating provider. That exception is why the general no-coverage rule is stated as applying to non-emergency care. Choice was not genuinely available in an emergency.

57. A — A flexible spending account is funded by employee salary reduction and is generally use-it-or-lose-it, subject to limited carryover or grace period provisions an employer may adopt. The health savings account requires a high deductible plan, belongs to the individual, is portable, and rolls over balances indefinitely. Only one account answers yes to both survival questions.

58. B — Custodial care assists with the ordinary activities of living and requires no medical training to provide, and it is covered by neither Medicare nor major medical insurance. Medicare covers limited skilled nursing after a qualifying hospital stay, and that stops at one hundred days in any benefit period. Custodial care is what people eventually need most.

59. D — The six activities of daily living are bathing, dressing, eating, toileting, transferring, and continence. Managing finances is an instrumental activity rather than one of the six, and inability to perform two of the six, or severe cognitive impairment standing alone, triggers benefits under a qualifying policy. Cognitive impairment triggers benefits independently as well.

60. A — Standardization means a given lettered plan provides identical core benefits regardless of which insurer issues it, so insurers compete on price and service rather than contract wording. Premiums are not standardized and vary considerably, which makes an honest comparison between identical letters purely a comparison of price. Comparison between identical letters is purely price.

61. C — A disability determination can extend the eighteen month period to twenty-nine months. Death of the covered employee, divorce, a dependent child ceasing to qualify, and the employee becoming entitled to Medicare all give dependents thirty-six months, while termination and reduced hours give eighteen. Identifying the qualifying event determines the duration.

62. B — A contributory plan requires employee contributions, so insurers accept a lower participation threshold, commonly seventy-five percent. A noncontributory plan is paid entirely by the employer, and because no employee declines free coverage, insurers ordinarily require one hundred percent participation to prevent adverse selection in the group. Both thresholds guard against adverse selection.

63. C — A hospital indemnity policy pays a stated amount for each day of confinement without any reference to what the hospital actually charged. Because it pays a fixed sum rather than reimbursing an expense, it sits outside coordination of benefits and stacks on top of whatever other coverage the member holds.

64. A — Dental plans tier services, paying preventive care such as cleanings at or near one hundred percent, basic restorative work such as fillings at a middle percentage, and major work such as crowns and bridges at a lower percentage. Orthodontia is usually a separate benefit with its own lifetime maximum. Annual maximums are low compared with medical plans.

65. D — Proof of loss is due within ninety days after the loss, or after the end of the period for which the insurer is liable. Notice of claim is due within twenty days, the insurer supplies forms within fifteen days, and legal action may be brought between sixty days and three years afterward.

66. B — Reinstatement governs restoration after a lapse. Where the insurer accepts a late premium without requiring an application, reinstatement is immediate. Where an application and conditional receipt are required, it occurs on approval or automatically after a stated number of days if the insurer has not declined it. The insurer's requirements determine which route applies.

67. B — Other insurance in this insurer is an optional provision addressing coverage held with the same company, permitting the insurer to limit total benefits and refund the excess premium collected. Insurance with other insurers is the parallel provision covering policies held with different companies entirely. A parallel provision covers other insurers entirely.

68. A — Moving to less hazardous work entitles the insured to a refund of the unearned premium computed at the lower rate. Moving to more hazardous work instead reduces benefits to what the premium paid would have purchased at the higher-risk rate, and that asymmetry between directions is what the provision tests.

69. D — Optionally renewable coverage permits the insurer to decline renewal at renewal dates only, rather than mid-term. Cancelable permits termination at any time on notice, guaranteed renewable requires renewal while permitting class premium increases, and noncancelable locks both the renewal and the premium to a stated age. The five classifications form a clear spectrum.

70. C — A future increase option permits the benefit amount to rise as earnings rise, subject to financial underwriting confirming the income supports the increase, but without new medical underwriting. It protects the same interest guaranteed insurability protects in life insurance, the ability to buy more after health deteriorates. Income growth rather than health governs the increase.

71. B — A recurrent disability provision treats a relapse from the same condition within the stated period as a continuation of the original claim rather than a new one. Because four months falls inside the

six month window, no new elimination period applies and benefits resume immediately on the same claim. Relapse inside the window continues the original claim.

72. A — Major medical coverage subject to federal reform generally may not impose preexisting condition exclusions. Excepted benefits fall outside those requirements, and that category includes disability income, short-term medical, specified disease, hospital indemnity, and standalone dental and vision coverage, all of which may still exclude such conditions. Product category determines which rules apply here.

73. D — Skilled nursing coverage under Part A requires a qualifying prior hospital stay, pays in full for days one through twenty, carries substantial daily coinsurance for days twenty-one through one hundred, and ends entirely after that. Custodial care has never been covered at any point under any part of Medicare. Day counts remain stable while dollar amounts change.

74. D — Medicare Advantage replaces Original Medicare rather than supplementing it, so a Medigap policy sold to an Advantage enrollee has almost nothing to coordinate with or pay. Selling duplicate or unusable coverage to a Medicare beneficiary is among the most seriously treated agent violations under state rules. Duplicate coverage sales are treated very seriously.

75. C — Medicare pays first as the primary payer for a dual eligible, and Medicaid pays afterward for services Medicare does not cover and for cost sharing the beneficiary cannot meet. A dual eligible therefore has little practical use for a Medigap policy, because Medicaid already fills those gaps. Medigap adds little for a dual eligible.

76. C — Social Security requires inability to engage in any substantial gainful activity because of an impairment expected to result in death or last at least twelve months, which resembles the private any occupation standard. There is no partial benefit, so the determination is all or nothing rather than proportionate. No partial benefit exists under the public program.

77. B — A person's own employer plan is ordinarily primary for that person and secondary for their spouse. The birthday rule applies to dependent children covered by both parents rather than to the adults themselves, and neither plan requires the member to drop the other coverage held. The birthday rule governs children rather than adults.

78. A — Under standard coordination the secondary plan may pay the portion the primary left unpaid, up to what it would have paid alone. Nonduplication is stricter, paying only the excess of what the secondary would have paid over what the primary actually paid, which is frequently nothing at all. Nonduplication produces a markedly harsher outcome.

79. A — Income benefits are ordinarily subject to a waiting period of several days, and are commonly paid retroactively to the date of injury if the disability continues beyond a stated longer period. This differs importantly from a private elimination period, which is almost never paid retroactively once benefits begin. Private elimination periods are rarely paid retroactively.

80. D — Field underwriting means observing what the application cannot capture and communicating it to the insurer through the agent's report, which is not shown to the applicant. The observation informs

underwriting rather than deciding it, so declining the application on that basis alone would exceed the agent's role. The report informs underwriting rather than deciding it.

81. C — Signing a client's name is forgery regardless of verbal permission, and it is a ground for license revocation. Initialing a correction on the applicant's behalf is also improper, because corrections require the applicant's own initials, but signing the entire application in their name is the more serious act. Corrections require the applicant's own initials too.

82. B — Insurers offering products with cash value or investment features must maintain anti-money laundering programs, and agents selling those products receive training and must report suspicious activity when observed. There is no requirement to verify every payment source or to report every transaction exceeding a fixed dollar threshold. Cash value products carry the obligation.

83. D — An investigative consumer report gathers information about character, reputation, and lifestyle through personal interviews rather than from records alone, and the applicant may learn its nature and scope on request. Both report types fall under the Fair Credit Reporting Act and both require prior written notice to the applicant. Both types require prior written notice.

84. B — Implied authority covers acts not written into the agency contract but reasonably necessary to exercise express authority, such as using the insurer's forms and displaying its name. Binding substandard risks, waiving provisions, and amending applications all exceed any authority the entire contract provision permits an agent to hold. Written grants define what an agent may do.

85. C — Rebating is offering any valuable consideration not specified in the policy as an inducement to purchase, and it remains prohibited even where the client requests it. In most circumstances both the agent offering and the client accepting are in violation, and no notification makes the arrangement lawful. Both parties are generally in violation together.

86. A — Replacement occurs where existing coverage is terminated, lapsed, surrendered, reduced in value, or converted to paid-up or extended term in connection with a new purchase. Adding a rider, assigning collaterally, and changing a beneficiary all leave the existing coverage intact and are not replacement transactions. Conversion to extended term counts as replacement.

87. A — Churning generates replacement business for the commission with no benefit to the client, often within the same insurer's book of business. Twisting induces replacement through misrepresentation or an incomplete comparison. Sharing commission with a client is rebating, and concealing facts from an underwriter is a separate violation. Both are prohibited and both carry consequences.

88. D — Twisting is inducing replacement through misrepresentation or an incomplete comparison, and omitting that the contestable period and suicide clause both restart is exactly that. The client's interests are directly affected, because a claim in the first two years of the new policy could be contested. Suicide clause restart is equally material to disclose.

89. C — Premium funds are received in a fiduciary capacity and belong to the insurer, so they must be kept separate from the agent's own money and transmitted promptly. Commingling is prohibited

regardless of whether any money is lost, because mixed funds cannot afterward be traced or verified by a regulator. Mixed funds cannot afterward be traced or verified.

90. B — An insurer issuing on an application containing 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, which is precisely why an incomplete application should never be submitted for underwriting at all. Incomplete applications should never be submitted.

91. 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, including smoking status, health condition, and occupation, is lawful underwriting and remains the entire basis on which insurance is priced. Same class and same hazard is the operative test.

92. B — Defamation is making false statements that harm the reputation of an insurer, and it sits alongside misrepresentation, false advertising, rebating, boycott and coercion, unfair discrimination, commingling, and fraud among prohibited practices. Misrepresenting an insurer's financial condition also falls within the misrepresentation prohibition separately. Misrepresenting financial condition breaches another provision. Misrepresenting an insurer's financial condition breaches the misrepresentation provision as well.

93. A — The central illustration requirement is that guaranteed and non-guaranteed elements be clearly distinguished, so a prospect can see which figures the insurer stands behind and which depend on assumptions. Presenting a non-guaranteed projection as guaranteed is a misrepresentation whatever the illustration's own footnotes may state. Footnotes do not cure a misleading presentation.

94. D — 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 authorization rules governing medical information. It never becomes the agent's property and is not routinely filed with the state regulator. It never becomes the agent's own property.

95. A — The recognized warning signs are a third party funding premiums, a face amount unrelated to demonstrated need, an applicant with no independent reason for coverage, and an intention to assign ownership shortly after issue. A business buy-sell arrangement rests on genuine insurable interest between the partners. Genuine insurable interest distinguishes legitimate arrangements.

96. C — Agents must maintain records of insurance transactions and make them available to the Department on request. Records are the evidence that a transaction was conducted properly, so an agent unable to produce them is poorly placed to answer a complaint whatever the underlying facts of the matter may be. Records are the evidence of proper conduct.

97. B — The entire contract comprises the policy, the attached copy of the application, and any riders or endorsements, so oral statements form no part of the agreement. No change binds the insurer unless made in writing and approved by an executive officer, and an agent cannot alter the contract. Executive officer approval is required for changes.

98. D — Where premium accompanied the application under a receipt, coverage already attached on the terms of that receipt, so no statement of continued good health is required at delivery. The statement is collected where no premium was paid up front and coverage therefore does not attach until delivery in good health.

99. D — 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 nor the absence of premium handling makes payment to an unlicensed person lawful under the Insurance Code. Client consent cannot make the payment lawful.

100. A — Competent parties requires both sides to be legally capable of contracting, which excludes minors, persons adjudged mentally incompetent, and persons under the influence of drugs or alcohol at the time of contracting. The other three elements address entirely different requirements for forming a valid contract. Minors and incompetent persons are excluded likewise.

101. C — At least twelve of the twenty-four hours must be classroom or classroom-equivalent, which caps self-study at the remaining twelve. Three of the twenty-four must be ethics, counted within the total rather than added to it, and the same requirement applies in every renewal period rather than only the first. Ethics hours sit inside the total, not above it.

102. B — A license renewed within ninety days of expiration may be renewed on payment of an additional late fee. Between ninety days and one year it may be reinstated without retaking the examination, and after one year a new license must be obtained with the examination taken again from the beginning.

103. C — An applicant must be at least eighteen, submit fingerprints for state and federal criminal history checks, and pay the application fee. Sponsorship applies to a temporary license rather than a full one, and neither a degree nor a minimum residence period is required to obtain the license. Sponsorship applies to temporary licenses instead.

104. A — A temporary licensee may not obtain additional appointments beyond the sponsoring company. The temporary license runs one hundred eighty days, cannot be renewed, and requires forty hours of training from the appointing company or agency within thirty days of the license application being filed. The sponsoring company is the only appointment permitted.

105. B — The Commissioner enforces the Insurance Code and adopts rules implementing it, may examine records, investigate, hold hearings, impose administrative penalties, and issue cease and desist orders. Enacting, amending, and repealing statutes are legislative functions, and a question suggesting otherwise describes something the office simply cannot do. Rules implement statutes rather than creating them.

106. D — Classification turns on where the insurer was organized rather than where it does business or how large its presence is. Domestic means organized under Texas law, foreign under the law of another state, and alien under the law of another country, so an out-of-state American company is foreign. An out-of-state American company is foreign.

107. A — 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 an appointment on file is a violation regardless of the license held. Each additional appointment carries its own fee. Appointment fees attach to each company separately.

108. D — Annuity benefits are covered to \$250,000 in present value per individual life. Life insurance death benefits are limited to \$300,000, net cash surrender value to \$100,000, basic hospital and major medical to \$500,000, and other supplemental health such as Medicare supplement to \$200,000 per individual. Each coverage tier carries its own distinct limit.

109. B — Boycott, coercion, and intimidation restraining or monopolizing the business of insurance are prohibited practices, alongside misrepresentation, false advertising, defamation, rebating, unfair discrimination, commingling, and fraud. Recommending competitors, explaining dividend uncertainty, and declining unsuitable business are all entirely proper professional conduct. Truthful comparison remains entirely permissible conduct. Truthful comparison and declining unsuitable business remain entirely permissible professional conduct.

110. C — Administrative action taken against a licensee by another state or authority must be reported to the Department, as must felony convictions and a change of address within thirty days. Failing to make a required report is itself a ground for discipline, separate from whatever event prompted the obligation. The report obligation stands separately from the event.

111. A — The policy may provide for an interest charge on the unpaid premium during the grace period, and where it does the interest rate must be specified. The policy may also stipulate that an overdue premium is deducted from any settlement if the insured dies during the grace period. Overdue premium may also be deducted at death.

112. B — A Texas life policy becomes incontestable after two years from its date during the insured's lifetime, so at eighteen months it remains contestable for material misstatements in the application. Nonpayment of premium is separately excepted, and the wartime military service carve-out applies at the insurer's option. Two years from the policy date is the standard.

113. C — Term life and pure endowment policies are not required to provide loans even where they happen to generate cash values, because the loan requirement attaches to the type of policy rather than to the presence of value. Permanent forms must offer loans after premiums for three full years have been paid.

114. D — 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, and their combined purpose is to let a buyer compare competing products on a genuinely common basis. The policy summary covers the specific contract instead.

115. A — 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 a projection nobody approved, exposing both agent and insurer to a misrepresentation claim.

116. B — The replacing agent determines whether replacement is involved by asking the applicant, presents the required notice regarding replacement, obtains signatures, submits a statement identifying the coverage being replaced, and provides copies of sales material used. The existing insurer's consent is never required for the transaction to proceed. Sales material used must also be supplied.

117. 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. The applicant then weighs both positions together.

118. C — The law prescribes minimum nonforfeiture values and requires a table of guaranteed values in the policy showing benefits available at the end of a series of policy years. An insurer may provide more generous values, and many do, but it may never fall below the printed guaranteed schedule. A guaranteed value table must appear in the policy.

119. B — 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 the member's attained age. The right is most valuable to someone now uninsurable and disappears once the conversion window closes. The window closes and does not reopen later.

120. D — 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. Credit insurance may not lawfully be made a condition of obtaining the underlying loan from the creditor. Coverage decreases as the loan amortizes downward.

121. A — Coverage attaches from the moment of birth without prior enrollment, but the plan may require that the parent notify the carrier of the birth and pay any additional premium for coverage to continue beyond the initial period. No medical questionnaire or pre-birth enrollment may be required as a condition. Immediate care is covered while paperwork continues.

122. C — A Medicare supplement policy may not be canceled or non-renewed on the ground of health status or claims experience, and age alone is never a ground. Nonpayment of premium and material misrepresentation remain legitimate grounds, and that restriction is what makes the coverage dependable for an aging population. Age alone is never a permissible ground.

123. B — An insurer may underwrite on medical evidence of a condition but may never underwrite on sexual orientation or use proxies such as occupation or living arrangements to infer it. Results are confidential and are ordinarily communicated to a physician or qualified person the applicant designates rather than to an employer.

124. A — The Texas small employer framework has long operated on a band of two to fifty eligible employees. Employers above that band are large employers for these purposes and fall outside the small

employer protections, including guaranteed issue and the constrained rating rules that accompany it in that particular market. Larger employers negotiate on ordinary commercial terms.

125. 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 those requirements prevent withdrawal when a block turns unprofitable and return once conditions improve. Both requirements prevent opportunistic market exit.

126. C — Where a state does not establish its own exchange, a federally facilitated exchange operates there, and Texas uses the federal Marketplace. Plans are grouped into metal tiers reflecting actuarial value, meaning the share of expected costs the plan pays rather than any measure of clinical quality. Metal tiers describe cost sharing rather than quality.

127. B — The premium tax credit reduces the cost of a Marketplace plan for eligible households and may be taken in advance against monthly premiums or claimed at filing. Cost-sharing reductions are a separate support with different eligibility, lowering deductibles and copayments only with a plan at the designated tier. The two supports have different eligibility rules.

128. D — An evidence of coverage sets 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, group insurers issue certificates under a master contract, and HMOs issue evidences of coverage. Departmental approval precedes any use of it.

129. C — Texas provides mechanisms addressing what an enrollee may be billed where an out-of-network provider treated them at an in-network facility and they had no genuine opportunity to choose. Emergency care is protected on the same reasoning, that the absence of real choice is what triggers the protection. Emergency care rests on the same reasoning.

130. A — Nonpayment of premium, fraud, material misrepresentation, and permanently moving outside the service area all remain legitimate grounds for nonrenewal. Health status, diagnosis, volume of services used, and the filing of a complaint with the Department are never permissible grounds, and acting on them would itself be a violation. Health status is never a permissible ground.