

PRACTICE EXAM 9: 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. A thirty-year-old teacher wants coverage lasting her whole life with values she can rely on, and can afford a steady annual payment. She should be shown:

- A. annually renewable term, repriced at every anniversary
- B. variable universal life with subaccount direction
- C. a single-premium contract funded from savings
- D. ordinary whole life, with guaranteed level premiums

2. An owner has funded a universal life contract generously for nine years and now wishes to raise the death benefit. The insurer will require:

- A. a fresh application and a new contestable period
- B. the beneficiary's written consent to the change
- C. evidence of insurability for the increased amount
- D. surrender of the existing contract and reissue

3. A client asks why his whole life premium never rises even though the risk of his death climbs every year. The explanation is that:

- A. early payments exceed the true cost, building reserve

- B. the insurer subsidises older insureds from new business
- C. the death benefit quietly falls as he ages
- D. state law forbids increases after the first year

4. A couple in their forties wants the maximum death benefit their budget allows while children are at home. The efficient choice is:

- A. twenty-pay whole life at a reduced face amount
- B. universal life funded at the minimum premium
- C. level term insurance for the dependency years
- D. a survivorship policy paying at the second death

5. An insured wants a contract in which she directs how the cash value is invested and accepts the consequences. She is describing:

- A. indexed universal life, measured against an index
- B. variable universal life, using separate subaccounts
- C. interest-sensitive whole life crediting current rates
- D. ordinary whole life with guaranteed cash values

6. An owner elects a dividend option that raises neither her death benefit nor her cash value but reduces what she pays. She chose:

- A. paid-up additions, buying permanent increments
- B. accumulation at interest with the insurer
- C. one-year term, purchasing annual protection
- D. premium reduction, applied to the next payment

7. A policyowner who has paid premiums for twenty-two years stops paying and elects a smaller policy she will never pay for again. She chose:

- A. extended term at the full original face amount
- B. cash surrender, ending all insurance protection
- C. an automatic premium loan against cash value
- D. reduced paid-up, permanent at a lower amount

8. A term policy is described as both renewable and convertible. Together these features protect the insured against:

- A. rising premiums as she reaches an older age
- B. becoming uninsurable during the policy term
- C. the insurer withdrawing from the state entirely
- D. inflation eroding the real death benefit value

9. An insured aged fifty-nine surrenders a policy for eighty-four thousand having paid sixty-one thousand in premiums. She must report:

- A. twenty-three thousand as ordinary income
- B. eighty-four thousand as ordinary income
- C. twenty-three thousand as long-term capital gain
- D. nothing, since insurance proceeds are exempt

10. An applicant asks whether the agent's spoken assurance about a policy exclusion will bind the insurer. The correct answer is:

- A. yes, since the agent represents the insurer
- B. yes, once the policy has been delivered
- C. no, because only attached documents form the contract
- D. no, unless the assurance was recorded in writing by the agent

11. A woman names her brother irrevocable beneficiary, then wants to surrender the policy for cash. She may do so:

- A. freely, since surrender is an owner's right
- B. only after giving her brother sixty days notice
- C. only with her brother's written consent
- D. only by first converting to a revocable designation

12. A policy is delivered on 8 February and the owner returns it on 19 February under the free look. The insurer must:

- A. refund the premium less an administrative fee
- B. refund only the unearned portion of premium
- C. retain the premium, coverage having been in force
- D. refund the entire premium paid, with no deduction

13. An insured dies twenty-one months after issue and the insurer finds a material misstatement about a prior stroke. The insurer may:

- A. rescind the contract and refund the premiums paid
- B. pay the death benefit reduced to a rated amount
- C. deny the claim and retain the premiums collected
- D. pay in full, the misstatement being innocent

14. A man names his three daughters per stirpes. One daughter dies before him leaving a single child. On his death that grandchild receives:

- A. nothing, the share passing to the surviving daughters
- B. her deceased mother's full one third share
- C. one sixth, being half of her mother's share
- D. one quarter, sharing equally with the daughters

15. An insured with an accidental death rider dies eight months after a car accident from injuries sustained in it. The rider will most likely:

- A. pay in full, since the accident caused the death
- B. pay half, reflecting the delay before death
- C. not pay, the stated period having elapsed
- D. not pay, since only instant death qualifies

16. An owner takes a policy loan and never repays it, and the insured lives another twenty years. During that time the loan:

- A. must be repaid before any dividend may be paid
- B. accrues interest, increasing the amount deducted at death
- C. is forgiven automatically after seven policy years
- D. causes the policy to lapse on the next anniversary

17. An insured buys a policy on 2 March and dies by suicide on 20 January of the second following year. The insurer will:

- A. refund the premiums paid and pay no death benefit
- B. pay the full face amount to the beneficiary
- C. pay the accumulated cash value to the estate
- D. deny the claim and retain the premiums collected

18. A father owns a policy on his ten-year-old son and becomes permanently disabled. A payor benefit rider will:

- A. pay the son a monthly income until he is eighteen
- B. convert the child's policy to permanent coverage
- C. transfer ownership of the policy to the child
- D. waive the premiums until the child reaches a stated age

19. An annuitant of sixty-eight wants income for life and wants his estate to receive at least what he paid in if he dies early. He should elect:

- A. life only, producing the largest monthly payment
- B. period certain for fifteen years, then ending
- C. a refund option, guaranteeing the purchase amount
- D. a fixed amount option depleting the fund

20. An owner of a deferred annuity worth ninety thousand, of which thirty thousand is gain, withdraws twenty thousand before annuitizing. The taxable amount is:

- A. nothing, since the contract remains in force
- B. the full twenty thousand, drawn from gain first
- C. six thousand six hundred, by exclusion ratio
- D. only the amount exceeding her original investment

21. A woman contributes to an annuity for eighteen years, then converts the value into monthly income for life. The moment of conversion is:

- A. the end of the free withdrawal period
- B. the start of the surrender charge schedule
- C. the beginning of the accumulation period
- D. annuitization, ordinarily irrevocable once made

22. A participant in a traditional qualified plan retires and takes distributions. The amount taxable as ordinary income is:

- A. the whole distribution, no basis having been created
- B. only the growth above contributions previously made
- C. nothing, the plan having been federally qualified
- D. half, with the balance treated as return of capital

23. A saver wants an arrangement funded with taxed dollars now so that qualified withdrawals later come out untaxed. She should use:

- A. a traditional individual retirement arrangement
- B. a Roth individual retirement arrangement
- C. a section 403(b) tax-sheltered annuity plan
- D. a simplified employee pension arrangement

24. A widow aged forty-eight caring for a twelve-year-old will lose Social Security survivor benefits when the child reaches the qualifying age, and resume them at retirement. The gap is:

- A. the elimination period before benefits commence
- B. the probationary period at the start of coverage
- C. the contestable period during which claims may be denied
- D. the blackout period, with nothing payable throughout

25. Six owners want each to insure every other under a cross-purchase arrangement. The number of policies is:

- A. six, one on each owner's life
- B. twelve, two on each owner's life
- C. thirty, each owner insuring the other five
- D. thirty-six, six policies on each owner

26. Whose tax bill does a benefit check create when the firm wrote off the disability premium as a business cost?

- A. taxable to the employee as ordinary income
- B. received by the employee free of income tax
- C. taxable only above the employee's prior earnings
- D. taxable to the employer rather than the employee

27. A physician cannot perform surgery after a hand injury but could examine patients. Her policy uses an own occupation definition, so she is:

- A. not disabled, since alternative medical work exists
- B. residually disabled, paid in proportion to earnings
- C. partially disabled, entitled to half the benefit
- D. totally disabled, unable to perform her own duties

28. Prior earnings were twelve thousand; she now brings home eight thousand. On a six thousand full benefit the residual payment is:

- A. four thousand, matching her lost earnings exactly
- B. three thousand, being half the full benefit
- C. two thousand, being one third of the benefit
- D. six thousand, the full monthly benefit amount

29. A veterinarian disabled for four months under a policy with a one hundred eighty day elimination period receives:

- A. benefits for the final thirty days of disability
- B. nothing, the elimination period being unsatisfied
- C. benefits paid retroactively to the onset date
- D. half benefits for the whole four month period

30. An accountant loses the use of both legs in a fall. Under a presumptive disability provision benefits will:

- A. begin immediately, without the elimination period
- B. begin once the elimination period is satisfied
- C. be paid at half the full monthly benefit
- D. begin only after vocational assessment is complete

31. Covered charges reach eighteen thousand. After a three thousand deductible the plan meets eighty percent. Her share totals:

- A. three thousand, being the deductible alone
- B. three thousand six hundred, twenty percent of charges
- C. six thousand, deductible plus twenty percent after
- D. three thousand, twenty percent after the deductible

32. A patient's plan reviews whether a hospital stay remains necessary while she is still an inpatient. This is:

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

33. An employee enrolled in a traditional low-deductible plan wants to open a health savings account. She:

- A. cannot, since a high deductible plan is required
- B. can, provided her employer also contributes
- C. can, but only up to half the annual limit
- D. can, provided she forfeits unused balances yearly

34. A man of eighty needs help with bathing, dressing, and toileting but has no acute medical condition. Under a long-term care policy he:

- A. does not qualify, since no nursing care is required
- B. qualifies, having lost more than two daily activities
- C. qualifies only after ninety days of facility confinement
- D. qualifies only where cognitive impairment is present

35. A sixty-five-year-old enrolling in Part B this month is refused a Medigap policy because of diabetes. The refusal is:

- A. lawful, since Medigap is medically underwritten
- B. lawful where the insurer offers another lettered plan
- C. unlawful, open enrollment guaranteeing issue
- D. lawful where the condition was diagnosed recently

36. A dependent child of a covered employee turns twenty-six and loses eligibility. Continuation coverage is available for:

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

37. An employer pays the whole group health premium and one employee declines coverage. The insurer is most likely to:

- A. object, since full participation is normally required
- B. accept, since participation rules apply only to contributory plans
- C. require the employee to pay the whole premium personally
- D. reduce benefits for all remaining employees proportionally

38. A member's claim notice reaches the insurer on the eighteenth day after the loss. The notice is:

- A. late, the requirement being ten days
- B. late, the requirement being fifteen days
- C. premature, since proof must accompany notice
- D. timely, the requirement being twenty days

39. An insured furnishes proof of loss and sues the insurer ninety days later. The action is:

- A. premature, since one hundred eighty days must pass

- B. timely, falling between sixty days and three years
- C. barred, since the outer limit is sixty days
- D. barred, since suit requires the insurer's consent

40. A woman moves from clerical work to commercial fishing and does not tell her disability insurer. After an injury the insurer will:

- A. void the policy from the date of the change
- B. deny the claim for failing to give notice
- C. pay what her premium would have bought at that risk
- D. pay in full and invoice the additional premium

41. An insurer wishes to exclude coverage for injuries an insured sustains while driving over the legal alcohol limit. It relies on:

- A. a mandatory uniform provision protecting the insured
- B. an optional provision addressing intoxicants and narcotics
- C. the entire contract provision limiting the documents
- D. the time limit on certain defenses barring contest

42. An insured has a policy the insurer must renew to age sixty-five but on which premiums may rise for everyone in her rating class. The classification is:

- A. guaranteed renewable, permitting class increases
- B. noncancelable, locking renewal and premium alike
- C. optionally renewable, permitting decline at anniversaries
- D. cancelable, permitting mid-term termination on notice

43. An insured reinstates a lapsed health policy on 1 June and develops pneumonia on 8 June. The claim will be:

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

44. An agent recording an application notices the applicant's stated age conflicts with the date of birth given. The agent should:

- A. clarify with the applicant and have the correction initialed
- B. amend the entry personally to make the form consistent
- C. submit it and allow underwriting to resolve the conflict
- D. omit the age entirely and rely on the birth date

45. An insurer wants to know whether an applicant's account of her medical history is complete and consults a member-insurer exchange. That exchange:

- A. provides underwriting decisions made by other insurers
- B. provides coded prior findings, never a decision
- C. provides the applicant's complete medical records
- D. provides financial and lifestyle information gathered locally

46. An insurer wants to know about an applicant's finances, occupation, and general reputation. The source it will use is:

- A. an attending physician statement from her doctor
- B. a paramedical examination arranged locally
- C. an inspection or consumer report from an agency
- D. the member-insurer coded information exchange

47. A prospect is quoted standard rates, then issued at a rating after a poor medical report. His options are to:

- A. insist on the original quotation as binding
- B. accept the policy and dispute the rating afterward
- C. treat the policy as void and demand a refund
- D. pay the increased premium or decline delivery

48. An agent knows an applicant misstated a hospital admission but submits the form regardless. The agent has:

- A. acted properly, since underwriting will detect it
- B. protected the applicant's privacy appropriately
- C. participated in the misrepresentation personally
- D. transferred all liability to the applicant signing

49. An applicant paying with a check drawn on an unrelated company's account, with no explanation, should prompt the agent to:

- A. treat third-party funding as a laundering indicator
- B. accept it, since the source of funds is irrelevant
- C. require the company to be named as beneficiary
- D. reduce the face amount to match the payment

50. An investor proposes funding premiums on a policy insuring a man he has never met, taking ownership in three years. The agent should:

- A. submit the file with a note for underwriting
- B. decline the business, the warning signs being present
- C. restructure it as a collateral assignment instead
- D. proceed once the insured signs a consent form

51. A member's plan pays eighty percent after the deductible until she reaches her annual ceiling, after which it pays everything. That ceiling is the:

- A. out-of-pocket maximum for the plan year
- B. deductible applied before benefits begin
- C. copayment charged for each covered service
- D. usual and customary limit on provider charges

52. A patient sees a specialist directly, without any referral, and her plan pays the full network benefit. Her plan is most likely:

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

53. A physician group contracts with an HMO while continuing to treat its own private patients. The arrangement is:

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

54. An employee leaving her job wants to keep the unspent balance in her medical account. She may only if the account is:

- A. a flexible spending account funded by salary reduction
- B. a health reimbursement arrangement funded by her employer
- C. either of those, both being portable by federal rule
- D. a health savings account, which she owns personally

55. A woman of seventy-nine cannot safely be left alone because of dementia, though she dresses and feeds herself. Her long-term care policy:

- A. pays, cognitive impairment being an independent trigger
- B. does not pay until two daily activities are lost
- C. pays only after ninety days of facility confinement
- D. pays only where a physician certifies terminal illness

56. A daughter caring for her mother full time needs a fortnight's break. The long-term care benefit responding is:

- A. skilled nursing care ordered by a physician
- B. adult day care attended during working hours
- C. respite care, relieving the family caregiver
- D. home health care delivered on a continuing basis

57. A beneficiary is admitted to hospital, discharged, and readmitted fifty days later. For Part A purposes the second admission:

- A. begins a fresh benefit period with a new deductible
- B. draws immediately on the lifetime reserve days
- C. is excluded as a readmission within sixty days
- D. continues the benefit period already open

58. A beneficiary asks why her Part B claims leave her paying twenty percent with no annual ceiling. The answer is that Part B:

- A. applies a lifetime maximum instead of an annual one
- B. pays eighty percent with no out-of-pocket maximum
- C. pays fifty percent until a supplement is purchased
- D. pays in full once the annual deductible is met

59. A man of sixty-two with amyotrophic lateral sclerosis applies for Medicare. He is:

- A. ineligible until he reaches sixty-five
- B. eligible after twenty-four months of disability benefits
- C. eligible only if he also has end-stage renal disease
- D. eligible without the twenty-four month waiting period

60. Long-term nursing home care for someone with almost no assets is most likely funded by:

- A. Medicare Part A, without any duration limit
- B. Medicare Part B, at eighty percent of charges
- C. Medicaid, subject to income and resource limits
- D. Social Security, through a disability determination

61. A child is covered under both parents' plans. The father's birthday is 9 January and the mother's is 22 November. Primary is:

- A. the father's plan, his birthday falling earlier in the year
- B. the mother's plan, as the parent with later coverage
- C. whichever plan the parents jointly nominate
- D. both plans equally, each paying half of every claim

62. Nine hundred was already paid by the first plan. A second plan whose own benefit would be seven hundred now owes:

- A. seven hundred, its full ordinary benefit
- B. nothing, the primary having paid more
- C. two hundred, the difference between the sums
- D. sixteen hundred, the total of both figures

63. An employee injured at work holds a policy written on a non-occupational basis. From that policy he will receive:

- A. full benefits, coordinated with workers compensation
- B. nothing, occupational injury being excluded
- C. half benefits, reflecting the shared exposure
- D. benefits once workers compensation is exhausted

64. A worker's employer never subscribed to the Texas compensation system. If he is injured, his employer:

- A. is covered automatically by a state assigned pool
- B. must obtain retroactive coverage within thirty days
- C. has forfeited the exclusive remedy protection
- D. faces criminal liability for the non-subscription

65. A plan pays a claim, then recovers the same amount from the driver who caused the accident. The plan exercised:

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

66. An agent is asked whether she may keep a client's premium in her own account until the policy issues. The answer is:

- A. yes, provided the funds are transmitted eventually
- B. yes, provided no interest is earned on the money
- C. yes, since the agent holds them for the client
- D. no, since commingling is prohibited outright

67. An agent produces her own version of an insurer's illustration showing figures she considers realistic. This is:

- A. acceptable where her figures are lower than the insurer's
- B. prohibited, the illustration being the insurer's representation
- C. acceptable where she signs and dates each page
- D. prohibited only where her figures exceed the insurer's

68. A client is shown only that a new policy costs eleven dollars less each month than his existing one. The comparison is:

- A. adequate, since price was his stated concern
- B. adequate, since the policy itself discloses the rest
- C. incomplete, but permissible where he agrees in writing
- D. incomplete, and inducing replacement on it is twisting

69. An agent asks a client to pay her personally so she can pass on a share of her commission as a discount. This is:

- A. acceptable where the insurer is notified in writing
- B. acceptable because the client benefits financially
- C. rebating, prohibited even where the client agrees
- D. acceptable where the amount is genuinely nominal

70. An agent tells a prospect a competitor's claims department routinely refuses valid claims, without any basis. This is:

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

71. A Texas producer completes twenty-four hours of continuing education, of which two are ethics. She has:

- A. satisfied the requirement, since the total is met
- B. exceeded the requirement by one full hour
- C. fallen short, three ethics hours being required
- D. satisfied it provided all were classroom hours

72. A Texas producer born in July lets the license lapse and does nothing for five months. She may now:

- A. renew late by paying an additional fee
- B. apply for reinstatement without retaking the examination
- C. continue working while an application is processed
- D. do nothing until the next July renewal cycle

73. A sponsored Texas applicant begins work under a temporary license on 1 March. Her company training must be completed by:

- A. 31 March, being thirty days from the application
- B. 1 June, being ninety days from the application
- C. 28 August, being one hundred eighty days
- D. 1 March the following year, at renewal

74. A Texas candidate passed the examination sixteen months ago and now applies. The Department will:

- A. issue the license on payment of a late fee
- B. issue it once forty hours of education are completed
- C. issue it with the Commissioner's written waiver
- D. require the examination to be taken again

75. Where a carrier was incorporated in Paris but admitted to do business in Texas, the Code labels it:

- A. a foreign insurer, organized outside this state

- B. a domestic insurer, once it is admitted here
- C. an alien insurer, organized outside the United States
- D. an unauthorised insurer regardless of admission

76. An agent begins writing business for a second insurer that has filed nothing with the Department. She has:

- A. acted lawfully, her license covering the line
- B. violated the requirement for a filed appointment
- C. until ninety days to have the filing completed
- D. acted lawfully provided the insurer is admitted

77. Death benefits totalling one hundred eighty thousand are owed by a failed Texas insurer. The association will cover:

- A. one hundred thousand, the cash surrender limit
- B. three hundred thousand, the maximum available
- C. ninety thousand, being half the total sum
- D. one hundred eighty thousand, being under the cap

78. An agent's brochure mentions that the guaranty association protects policyholders if an insurer fails. Including that is:

- A. prohibited, in written and spoken presentations alike
- B. permitted where the limits are stated accurately
- C. permitted where the insurer is financially strong
- D. permitted in brochures but not in conversation

79. Payment was due 12 September and never arrived. Expressed in days, protection continues at minimum until:

- A. 22 September, being ten days later
- B. 13 October, being thirty-one days later
- C. 2 October, being twenty days later
- D. 12 November, being two months later

80. Thirty-four months into a Texas contract, a lie on the application surfaces while the insured lives. The company may:

- A. rescind the contract and refund the premiums
- B. reduce the benefit to reflect a proper rating
- C. cancel the policy prospectively without refund
- D. not contest, the policy now being incontestable

81. Twenty-six months of premiums have been paid on a Texas whole life contract. A borrowing request must be:

- A. must make the loan, since cash value exists
- B. must make the loan at a statutory interest rate
- C. need not make it, three full years being required
- D. must make it only where the policy participates

82. An age understated by four years surfaces at claim time in Texas. Settlement will be:

- A. adjust the benefit to what the premium purchased
- B. void the policy and return the premiums received
- C. pay the full face amount without any adjustment
- D. deny the claim for material misrepresentation

83. A Texas advertisement is composed entirely of accurate statements arranged so a reader believes coverage is broader than it is. The advertisement is:

- A. acceptable, since no statement is untrue
- B. acceptable once the Commissioner approves the form
- C. misleading, judged by the overall impression created
- D. acceptable where a disclaimer appears in the text

84. A Texas annuity buyer receives the Buyer's Guide and disclosure document at the time she applies. Her free look is:

- A. whatever the contract provides, the fifteen day rule not triggered
- B. fifteen calendar days in every case regardless
- C. thirty calendar days from the contract's issue
- D. ten calendar days from receiving the contract

85. A Texas client lets an existing policy lapse in order to fund premiums on a new one from another insurer. The transaction is:

- A. not a replacement, since nothing was surrendered
- B. not a replacement, since the insurers differ
- C. a replacement only where the face amounts match
- D. a replacement, triggering the prescribed notices

86. A Texas replacing insurer receives an application marked as a replacement. It must:

- A. obtain the existing insurer's written consent
- B. notify the existing insurer of the proposed replacement
- C. delay issue for ninety days pending a response
- D. submit the file to the Department for approval

87. Guaranteed year-end figures printed inside a Texas permanent contract represent amounts the company may:

- A. reduce them where its investment results disappoint
- B. provide more generous values but never less
- C. waive them where the policyowner agrees in writing
- D. apply them only after ten policy years have elapsed

88. Leaving her employer, a Texas group member converts inside the permitted window. Pricing will reflect:

- A. supply satisfactory evidence of insurability first
- B. accept a policy priced at her original entry age
- C. wait until the group policy itself terminates
- D. pay a premium based on her attained age

89. A Texas lender writes credit life coverage for twice the outstanding loan balance. This is:

- A. permitted where the borrower requested it
- B. permitted since the creditor bears the risk
- C. prohibited, coverage not exceeding the indebtedness
- D. permitted where the loan may later increase

90. A baby is born to a covered Texas parent and needs intensive care from the first hour. The plan:

- A. covers the care, coverage attaching at birth
- B. covers it once the enrollment form is filed
- C. excludes it as a condition existing at birth
- D. covers it from the start of the next plan month

91. A Texas insurer wishes to non-renew a Medicare supplement policy because the insured has claimed heavily. This is:

- A. permitted where sixty days notice is given

- B. permitted where the unearned premium is refunded
- C. prohibited, claims experience being no ground
- D. permitted where an alternative plan is offered

92. Relying on the general medical authorization, a Texas company plans to screen an applicant's blood for HIV. It:

- A. may proceed, the authorization covering all tests
- B. may proceed if the applicant is told afterward
- C. may proceed where the face amount is substantial
- D. may not proceed without separate written consent

93. Forty-nine workers, a poor claims record, and an application for group cover in Texas. The carrier is obliged to:

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

94. A Texas employer meets every eligibility test but contributes nothing toward premium, against a carrier requirement. The carrier may:

- A. decline, the ground being the arrangement itself
- B. not decline, since guaranteed issue is absolute
- C. decline only with the Commissioner's approval
- D. decline only where fewer than two employees enrol

95. A patient asks why her routine cholesterol screening produced no bill at all. The reason is:

- A. her deductible was satisfied earlier that year

- B. the laboratory waived the charge as a courtesy
- C. screenings are excluded from her plan entirely
- D. required preventive services carry no cost sharing

96. A Texas resident buying individual coverage under federal reform will do so through:

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

97. An enrollee asks whether a silver plan means better doctors than a bronze plan. The correct answer is that tiers indicate:

- A. the clinical qualifications of network physicians
- B. the geographic breadth of the provider network
- C. the share of expected costs the plan pays
- D. the financial strength rating of the insurer

98. Entitlements and their conditions reach a Texas HMO member in a document cleared by the Department. That document is:

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

99. After moving permanently to Oklahoma, far beyond the service area, a Texas HMO member finds the plan may:

- A. decline to renew, relocation being a valid ground

- B. continue coverage at an increased premium only
- C. require her to return to Texas for all care
- D. terminate coverage immediately without notice

100. Struck down at an airport far from her network, an enrollee is treated at the nearest hospital. That treatment is:

- A. denied absent prior authorization from the HMO
- B. reimbursed at half the in-network benefit level
- C. paid by the enrollee and reclaimed at renewal
- D. covered without regard to the provider's network

101. Holding two Texas licenses, a producer wonders whether her education burden doubles. It:

- A. doubles to forty-eight hours across the period
- B. rises by half, to thirty-six hours in total
- C. stays at twenty-four hours across both licenses
- D. alternates, twenty-four hours for each in turn

102. Four hours of the required education were never completed by a Texas producer. The Department will:

- A. revoke the license immediately on discovery
- B. assess a fine for each hour left outstanding
- C. issue a written warning carrying no penalty
- D. suspend the license until the next renewal

103. A Texas producer relocates her office and updates the appointing insurer but tells nobody else. She has:

- A. failed to notify the Department within thirty days

- B. satisfied the obligation by informing the insurer
- C. until her next renewal to update the Department
- D. no obligation, no address appearing on the license

104. Which power does the Texas Insurance Code withhold from the Commissioner?

- A. Examining a licensee's books and records
- B. Issuing a cease and desist order against conduct
- C. Repealing a statutory provision that has become obsolete
- D. Imposing an administrative penalty after a hearing

105. A referral from an unlicensed acquaintance produces a sale, and the agent wants to share the commission. She may:

- A. pay a nominal referral fee without difficulty
- B. pay it where the client consents in writing
- C. pay it where the acquaintance sold nothing herself
- D. not pay anything, the acquaintance being unlicensed

106. Two Texas applicants of identical age, health, and occupation receive different quotations from one insurer. The practice is:

- A. lawful individual underwriting of each applicant
- B. unfair discrimination between insureds of one class
- C. rebating, since one applicant gained an advantage
- D. lawful where both quotations were made honestly

107. An annuity contract with a present value of four hundred thousand dollars is left stranded by a Texas insurer's insolvency. Guaranty cover is:

- A. four hundred thousand, matching the contract value

- B. three hundred thousand, the death benefit limit
- C. two hundred fifty thousand, the annuity limit
- D. one hundred thousand, the cash surrender limit

108. Basic hospital and major medical benefits owed by a failed Texas insurer are protected up to:

- A. one hundred thousand dollars per individual
- B. two hundred thousand dollars per individual
- C. three hundred thousand dollars per individual
- D. five hundred thousand dollars per individual

109. A worried Texas prospect is told the guaranty association would step in if the company failed. That reinsurance is:

- A. permitted where the coverage limits are stated accurately
- B. prohibited, the association not being a selling point
- C. permitted where the insurer's rating is below average
- D. permitted in conversation though not in writing

110. Only where the contract states the rate may a Texas insurer levy something on premium unpaid during the month of grace. That something is:

- A. interest on the overdue premium amount
- B. a reinstatement fee added to the balance
- C. a penalty equal to one month's premium
- D. an administrative charge set by the Department

111. Sixteen months after a Texas policy issued, a material misstatement in the application comes to light. The insurer may:

- A. not contest, the two year period having run

- B. contest only for nonpayment of the premium
- C. contest, the incontestable period not yet complete
- D. reduce the benefit rather than contest at all

112. Cash value has accrued incidentally within a Texas term contract, and the owner asks to borrow. The insurer:

- A. must lend once three years of premiums are paid
- B. must lend immediately, value being present
- C. must lend only where the contract participates
- D. need not lend, term contracts being exempt

113. A Texas prospect has received a booklet explaining insurance in general terms. She remains entitled to:

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

114. Told that an illustration's projected figures are what his policy will pay, a Texas prospect has been:

- A. correctly informed about the guaranteed column
- B. misled, non-guaranteed values being presented as certain
- C. correctly informed once he signs an acknowledgment
- D. correctly informed if the insurer prepared the document

115. A Texas client surrenders an existing policy to fund a new one from a different company. Before proceeding the agent must:

- A. obtain the existing insurer's written consent

- B. delay the application by sixty days
- C. present the replacement notice and obtain signatures
- D. submit the transaction to the Department

116. Guaranteed values printed at the end of each policy year in a Texas contract exist because of:

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

117. Asked whether she must prove good health to convert her ending Texas group coverage, a departing member should be told:

- A. yes, evidence of insurability is always required
- B. yes, unless she held the coverage over ten years
- C. no, but only where the group policy is terminating
- D. no, conversion requires no evidence of insurability

118. A Texas lender makes approval of a loan conditional on the borrower buying credit life cover. The condition is:

- A. prohibited, such insurance not being requirable
- B. permitted, the lender carrying the credit risk
- C. permitted where the borrower signs a disclosure
- D. permitted where the sum matches the indebtedness

119. An infant born to a covered Texas parent requires surgery within hours of birth. The plan:

- A. pays once an enrollment form is submitted
- B. pays, coverage having attached at the moment of birth

- C. excludes the surgery as congenital in origin
- D. pays from the start of the following plan month

120. Returning a supplement contract on day twenty-nine of the review window entitles the Texas purchaser to:

- A. a prorated refund for the unused period only
- B. a refund reduced by an administrative charge
- C. nothing, thirty days having almost elapsed
- D. a full refund of the premium she has paid

121. An insurer proposes declining a Texas applicant because of assumptions drawn from his household arrangements. The decision is:

- A. permitted where a consented test result supports it
- B. permitted where actuarial data justifies the assumption
- C. prohibited, proxies not being usable to infer orientation
- D. permitted where the applicant is notified in writing

122. Necessary care for a member's chemical dependency must be treated by a Texas health benefit plan as:

- A. must cover the necessary care, as a mandated benefit
- B. may exclude it unless the employer elects otherwise
- C. may limit it to outpatient counseling alone
- D. may impose a twelve month waiting period first

123. An employer with fifty-three eligible workers seeks Texas group health coverage. That employer sits:

- A. inside the small employer band, entitled to guaranteed issue

- B. inside it provided a majority of workers enrol
- C. outside the band, negotiating on commercial terms
- D. outside it only where coverage was previously held

124. A Texas carrier decides to leave the small employer market altogether. Before doing so it must:

- A. give advance notice and accept a re-entry bar
- B. transfer its block to a willing successor carrier
- C. obtain written consent from each affected employer
- D. continue renewing existing groups for five years

125. Help with a household's deductible and copayments under federal reform is delivered through:

- A. the premium tax credit, taken monthly in advance
- B. an employer contribution required by federal law
- C. a state subsidy administered by the Department
- D. a cost-sharing reduction, tied to a designated tier

126. Alongside pediatric and preventive services, which third category does the outline single out for emphasis?

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

127. A large Texas employer asks what federal reform obliges it to do. The obligations include:

- A. buying every policy through the Marketplace
- B. an absolute prohibition on self-funded arrangements
- C. reporting on coverage offered and possible payments

D. exemption from telling employees about the exchange

128. A Texas HMO discovers an enrollee lied materially when she joined and cancels her coverage. The cancellation is:

- A. prohibited, only nonpayment permitting cancellation
- B. permitted, material misrepresentation being a valid ground
- C. permitted only with the Department's prior approval
- D. prohibited once coverage has run a full year

129. Treated during surgery by an out-of-network anesthetist inside a network hospital, a Texas enrollee is protected because:

- A. she had no meaningful opportunity to choose that provider
- B. every provider at a network facility counts as in network
- C. her gatekeeper referral extended to all hospital services
- D. the HMO must contract retroactively with the provider

130. A Texas agent briefly spends premium money on a personal bill and replaces it the following day. The Department may:

- A. take no action, restitution having been prompt
- B. issue a warning only, given the short duration
- C. act solely where a policyholder suffered loss
- D. revoke the license for misappropriating funds

Practice Exam 9: Answer Key and Explanations

1. D — Whole life guarantees a level premium, a level death benefit, and a schedule of cash values, and it endows at maturity. Term expires without permanence, variable products guarantee nothing beyond a

minimum death benefit, and a single premium demands capital she does not have available. Guarantees rather than flexibility are what she needs.

2. C — Universal life is adjustable, so the owner may raise or lower the face amount after issue, but evidence of insurability is required for an increase because the insurer is accepting additional mortality risk. A decrease needs no such evidence, since the insurer's exposure is being reduced. A decrease requires no evidence at all.

3. A — Mortality cost climbs every year while the premium stays flat, so early payments exceed the true cost of insuring the life. That accumulated overcharge becomes the guaranteed cash value, and it is precisely what allows the premium to remain level while the underlying risk rises steadily. The overcharge becomes guaranteed cash value.

4. C — Term insurance builds no cash value and provides pure protection, so every premium dollar beyond expenses buys mortality coverage and the face amount affordable is the largest available. Reducing the face amount to afford permanent coverage would leave the family underinsured during precisely the years of greatest exposure. Underinsuring during the dependency years is the real risk.

5. B — Variable products place cash value in separate account subaccounts the owner directs, with performance flowing straight through and no guaranteed minimum rate, so the owner bears the investment risk. Because the contract is a security, selling it requires a securities registration in addition to an insurance license. Securities registration is required to sell it.

6. D — Premium reduction applies the dividend against the next premium due, lowering the owner's outlay without adding coverage or value. Paid-up additions raise both death benefit and cash value, accumulation builds a side fund earning taxable interest, and one-year term buys temporary protection instead. Only the owner's outlay is affected. Each dividend option directs the money differently.

7. D — Reduced paid-up applies the accumulated cash value as a single premium to buy a fully paid-up permanent policy at a smaller face amount, lasting for life with nothing further due. Extended term instead preserves the full face amount but only for a limited period of time. Amount is traded away to secure permanence.

8. B — Renewability extends the term without new evidence of insurability, and convertibility exchanges the term policy for permanent coverage on the same basis. Both respond to the same underlying risk of declining health, though renewal premiums still reflect attained age and conversion does not freeze the cost. Renewal premiums still reflect attained age.

9. A — On full surrender, any amount received above the total premiums paid is taxable as ordinary income, so the reportable gain is twenty-three thousand. Only death proceeds are generally received income-tax-free, and capital gain treatment does not apply to a life insurance surrender at all. Capital gain treatment never applies here.

10. C — The entire contract comprises the policy, the attached copy of the application, and any riders or endorsements, so spoken statements form no part of the agreement. No change binds the insurer unless

made in writing and approved by an executive officer of the company itself. Executive officer approval is required for changes.

11. C — An irrevocable beneficiary holds a vested interest, so consent is required to change the designation and also to surrender the policy, borrow against cash value, or assign the contract. The owner cannot unilaterally convert an irrevocable designation into a revocable one to escape the restriction. Vested interests are exactly what consent protects.

12. D — The free look gives the owner a stated number of days after delivery to examine the contract and return it for a full refund with no obligation and no deduction. The period runs from delivery, which is why a signed delivery receipt matters if the timing is later disputed. Delivery rather than issue starts the clock.

13. A — Twenty-one months falls inside the conventional two year contestable period, so a material misrepresentation permits the insurer to rescind and return premiums. Retaining premiums while denying the claim is not the remedy, and after two years incontestability would bar the contest entirely. Two years is the conventional contestable boundary. After two years incontestability would bar any contest.

14. B — Per stirpes means by the branch, so a deceased beneficiary's share passes to that beneficiary's own descendants. With a single child in that branch, the grandchild takes the entire third her mother would have received. Per capita would instead redistribute it among the surviving daughters. Per capita would redistribute among the survivors.

15. C — Accidental death benefits are ordinarily payable only where death occurs within a stated period after the accident, commonly ninety days, which establishes the causal link. Eight months exceeds that window, so the base policy pays while the rider adds nothing to the amount payable. Causation between accident and death must be shown.

16. B — A policy loan need not be repaid, but interest accrues throughout and the outstanding balance plus that interest is deducted from the death benefit. A loan left running for decades can consume a substantial share of the proceeds the beneficiary eventually receives from the contract. Interest compounds against the eventual proceeds.

17. A — The death occurred roughly twenty-three months after issue, inside the conventional two year suicide period, so the insurer refunds the premiums paid and pays no death benefit. Once the period expires, suicide is treated as any other cause and the full benefit becomes payable. Premiums are refunded rather than benefits paid.

18. D — 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 the loss of the person funding it. The child's coverage survives the funder's loss.

19. C — A refund option pays for life and guarantees that total payments will at least equal the amount paid in, continuing to a beneficiary under an installment refund or paying the balance in cash. Life only

guarantees nothing after death, and period certain is not contingent on life. Guarantees always reduce the periodic payment.

20. B — Withdrawals before annuitization are treated as coming from gain first and are fully taxable until the accumulated gain is exhausted. Because thirty thousand of gain exists, the whole twenty thousand is taxable. This reverses the exclusion ratio treatment applied after annuitization, and the reversal is deliberately tested. Ordering reverses entirely at annuitization.

21. D — Annuitization converts the accumulated value into a payment stream and is ordinarily irrevocable, so the lump sum is no longer available afterward. That is precisely why the choice of settlement option deserves careful consideration before payments begin rather than once they have already started. The lump sum is no longer available afterward.

22. A — Qualified plan contributions are made with pre-tax dollars, so the participant has no basis and the entire distribution is taxable as ordinary income rather than only the growth. Nonqualified arrangements funded with after-tax dollars create basis and tax only the gain on distribution. Pre-tax funding leaves no basis to recover.

23. B — 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 rather than at distribution. Tax is paid at the front rather than the back.

24. D — Benefits to a surviving spouse caring for a child cease when the youngest child reaches the qualifying age and do not resume until the spouse reaches retirement age. That interval is the blackout period, and it can run for decades without any survivor income being payable. Private coverage exists to fill that gap.

25. C — Under cross-purchase each owner insures every other owner, so six owners require six multiplied by five, giving thirty policies. The number grows steeply as owners are added, which is why larger firms prefer entity arrangements holding a single policy on each owner. Entity arrangements scale far more practically. Six owners each insuring five others produces thirty contracts.

26. A — Whoever paid the premium with untaxed dollars pays tax on the benefit. Because the employer paid and deducted the premium as a business expense, the benefits are taxable to the employee. Where the individual pays personally with after-tax income, benefits are received entirely free of tax. Untaxed money going in produces taxable benefits coming out afterward.

27. D — Own occupation asks only whether the insured can perform the duties of the specific occupation held, so a surgeon unable to operate qualifies even where other medical work remains possible. An any occupation definition would produce the opposite result on identical facts, which is why definition matters. Definition rather than diagnosis decides the claim.

28. C — Income loss is four thousand against prior earnings of twelve thousand, which is one third. Applying that proportion to the six thousand full benefit produces two thousand. Residual provisions

pay in proportion to income lost rather than paying the raw shortfall in monthly earnings. Proportion rather than the raw earnings shortfall governs the calculation.

29. B — The elimination period functions as a deductible measured in time, running from the onset of disability, and benefits begin only once it has been fully satisfied. A disability lasting four months never reaches one hundred eighty days, so nothing is payable and nothing is paid retroactively. Nothing is paid retroactively across the period.

30. A — Presumptive disability provisions deem the insured totally disabled on specified catastrophic losses such as sight in both eyes, hearing in both ears, speech, or the use of two limbs. Benefits typically begin immediately without the elimination period, and no proof of inability to work is needed. Catastrophic losses settle the question by themselves.

31. C — She pays the three thousand deductible first, leaving fifteen thousand subject to coinsurance. Twenty percent of fifteen thousand is three thousand, so her total is six thousand and the plan pays twelve thousand. Applying coinsurance before subtracting the deductible is the error the distractors capture. Applying coinsurance before the deductible is the planted error here.

32. D — Utilization review examines whether care is necessary and appropriately delivered. Precertification applies before treatment, concurrent review applies during a hospital stay or course of care, and retrospective review applies afterward. Failing to obtain required precertification ordinarily produces a reduced benefit rather than denial. Each review type applies at a different stage.

33. A — A health savings account must be paired with a qualifying high deductible health plan and cannot stand alone, so eligibility fails at the threshold regardless of contribution arrangements. The account belongs to the individual, is portable, and rolls unused balances over indefinitely once properly established. Pairing with a high deductible plan is mandatory.

34. B — Policies ordinarily pay when the insured cannot perform two of the six activities of daily living, which are bathing, dressing, eating, toileting, transferring, and continence. Losing three of them satisfies the trigger, and severe cognitive impairment is an independent alternative rather than a requirement. Cognitive impairment stands as an independent trigger.

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

36. D — A dependent child ceasing to qualify is a thirty-six month qualifying event, as are death of the covered employee, divorce or legal separation, and the employee becoming entitled to Medicare. Termination and reduced hours produce eighteen months, extendable to twenty-nine on a disability determination. Identifying the qualifying event determines duration.

37. A — A noncontributory plan is paid entirely by the employer, and because no employee declines free coverage, insurers ordinarily require one hundred percent participation. Contributory plans require employee contributions and accept a lower threshold, commonly seventy-five percent, and both

requirements prevent adverse selection. Participation thresholds guard against adverse selection. Free coverage that anyone declines signals adverse selection risk.

38. D — Notice of claim is due within twenty days after the loss, or as soon thereafter as reasonably possible, so notice on day eighteen is timely. The insurer must then supply claim forms within fifteen days, and proof of loss follows within ninety days of the loss. Reasonableness is judged on the claimant's circumstances.

39. B — The legal actions provision bars suit until sixty days after proof of loss has been furnished and bars suit brought more than three years afterward. Ninety days falls comfortably between those boundaries, so the action is timely and neither premature nor out of time. The window is bounded at both ends deliberately.

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

41. B — The intoxicants and narcotics provision is optional and permits exclusion of loss sustained while the insured was intoxicated or under the influence of narcotics other than as administered on a physician's advice. Mandatory provisions such as grace period and proof of loss protect the insured instead. Sorting provisions into the two lists is tested.

42. A — 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 worsened. Noncancelable locks both the renewal and the premium, making it the more favorable classification. Singling out one insured is never permitted.

43. D — On reinstatement of a health policy, accidents are covered immediately but sickness only after ten days. The gap exists to prevent someone reinstating a lapsed policy because they have already begun to feel unwell, and an illness arising on day seven falls squarely inside that window. Accidents by contrast are covered immediately.

44. A — Field underwriting requires recording the applicant's answers accurately, and a correction must be initialed by the applicant rather than made by the agent alone. Clarifying an apparent conflict before submission is exactly why a person meets the applicant rather than a form being posted. Only the applicant's own hand makes it theirs.

45. 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 an application solely on the basis of an MIB code. It signals where to investigate rather than deciding.

46. C — 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 member-insurer exchange reports coded prior findings rather than financial or lifestyle

information about an applicant. Medical sources address health rather than lifestyle. Medical sources address health rather than lifestyle information.

47. D — A policy issued on terms other than those applied for is a counteroffer rather than an acceptance, so the applicant may accept by paying the modified premium and taking delivery, or may decline. The original quotation binds nobody, and no contract exists until the counteroffer is accepted. No contract exists until the counteroffer is accepted.

48. C — An agent who knows an application misstates a material fact and submits it anyway has participated in the misrepresentation, exposing themselves to disciplinary action independent of anything the insurer does. Detection likelihood and the applicant's signature neither excuse the conduct nor shift the responsibility elsewhere. Detection likelihood neither excuses nor shifts responsibility.

49. A — Payment from an unrelated third party is a recognized money laundering indicator, alongside indifference to product features combined with interest in surrender terms, unusual cash or structured payments, and early surrender accepted despite penalties. Agents selling cash value products are trained to report suspicious activity. Training teaches the pattern rather than isolated acts.

50. B — 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 of a stranger-originated arrangement. An agent who recognizes the pattern and submits anyway becomes a participant. Submitting anyway makes the agent a participant.

51. A — The out-of-pocket maximum caps what a member pays in a year, and once reached the plan pays covered expenses in full for the remainder. Charges above the usual, reasonable, and customary limit may still be billed separately and frequently do not count toward that maximum. Charges above customary limits often fall outside it.

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

53. B — An independent practice association contracts with physicians who continue their own private practices and also treat patients who are not HMO members. A staff model employs physicians directly, a group model contracts with one large multi-specialty group, and a network model contracts with several groups. Member choice differs across the four HMO models.

54. D — The health savings account belongs to the individual, so it is portable and follows the person when employment ends, and unused balances roll over indefinitely. A reimbursement arrangement is employer-owned and not portable, and a flexible spending account is generally use-it-or-lose-it at year end. Employer ownership explains the absence of portability.

55. A — Severe cognitive impairment is an independent benefit trigger, so an insured with advanced dementia may qualify while remaining physically able to perform every activity of daily living. The

alternative trigger requires inability to perform a stated number of those activities, ordinarily two of six. Physical capability does not defeat that claim.

56. C — Respite care provides temporary relief to an unpaid family caregiver, covering short periods of substitute care so the caregiver can rest. It is distinct from skilled nursing, adult day care, and continuing home health care, and its presence signals a long-term care contract rather than medical coverage. Its presence signals long-term care rather than medical cover.

57. D — A Part A benefit period ends only after sixty consecutive days out of a hospital or skilled nursing facility, so a readmission at fifty days continues the existing period and no new deductible applies. A readmission after sixty days would instead begin an entirely fresh benefit period. Sixty days is the threshold that resets it.

58. B — After the annual deductible, Part B pays eighty percent of the approved amount and the beneficiary is responsible for the remaining twenty percent, with no out-of-pocket maximum limiting the yearly total. That open-ended exposure is the largest single gap a Medicare supplement policy addresses. That gap is what a supplement is bought to fill.

59. D — End-stage renal disease and amyotrophic lateral sclerosis both bypass the twenty-four month waiting period that otherwise follows entitlement to Social Security disability benefits. No other diagnosis carries that exception, and the two are frequently tested alongside the general rule for beneficiaries under sixty-five. Both conditions progress too quickly for the wait.

60. C — Medicaid is needs-based and is the largest payer of long-term custodial care in the United States, which Medicare excludes entirely at every level. Eligibility depends on income and countable resources against state thresholds, and spend-down and lookback rules govern how assets are treated. Medicare excludes custodial care at every level.

61. A — 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 November and the father's plan is primary. A court order allocating responsibility governs instead where parents are separated or divorced. Year of birth is entirely irrelevant to the rule.

62. B — Under nonduplication the secondary plan pays only the excess, if any, of what it would have paid alone over what the primary actually paid. Because nine hundred exceeds seven hundred, nothing remains and the secondary pays nothing at all toward that claim. Standard coordination would treat the member more generously.

63. B — Non-occupational coverage excludes what workers compensation would cover, so an insured injured at work collects from that system and nothing from the private policy. Occupational or twenty-four-hour coverage protects in both settings instead, and the distinction frequently decides questions of this kind. Occupational coverage protects in both settings instead. Occupational or twenty-four-hour coverage protects in both settings instead.

64. C — Texas does not require most private employers to carry workers compensation, but an employer declining to subscribe forfeits important legal protections, principally the exclusive remedy

bar, and becomes exposed to suit by injured employees. No state pool supplies the coverage the employer declined. No state pool supplies what the employer declined.

65. A — Subrogation allows an insurer that has paid a claim to step into the insured's position and pursue the party responsible, placing the cost on the party at fault rather than on the premium-paying pool. It prevents recovery beyond actual loss, as coordination does between plans. Recovery beyond actual loss is what it prevents.

66. 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 ultimately lost, because mixed funds cannot afterward be traced or verified. Mixed funds cannot afterward be traced or verified.

67. 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 the figures more conservative. Doing so makes the agent the author of a projection nobody approved, exposing agent and insurer alike. Footnotes cannot cure an unauthorized projection.

68. D — Twisting is inducing replacement through misrepresentation or an incomplete comparison, and showing only a premium saving while omitting the restarted contestable period, restarted suicide clause, and current-age pricing is exactly that. A client's stated interest in price does not narrow the disclosure duty. Circumstances rather than price justify replacing coverage.

69. 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 agrees or requests it. In most circumstances both the agent offering and the client accepting are in violation together. Both parties are generally in violation together.

70. A — 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. Inducing a replacement on that footing would additionally amount to twisting. Truthful comparison remains permissible and expected. Inducing a replacement on that footing would additionally be twisting.

71. C — Three of the twenty-four hours must be ethics, counted inside the total rather than added to it, so completing only two leaves the licensee deficient. At least twelve of the twenty-four must also be classroom or classroom-equivalent, capping self-study at the remaining twelve hours. Ethics hours sit inside the total, never above it.

72. B — Between ninety days and one year after expiration a license cannot be renewed but may be reinstated without retaking the examination, by filing a new application with the license fee plus an additional fee. Within ninety days simple late renewal is available, and after a year the examination returns. Within ninety days simple late renewal is available.

73. A — The sponsored applicant must complete forty hours of training provided by the appointing company or agency within thirty days of the license application. The temporary license itself runs one

hundred eighty days, cannot be renewed, and the examination must be passed within that period. The temporary license itself cannot be renewed.

74. D — The license application must be filed within twelve months of passing, or the examination has to be taken again from the beginning. Sixteen months exceeds that window, so the earlier result no longer supports an application and the candidate must sit the examination once more. Passing alone never licenses anyone by itself.

75. C — Classification turns on where the insurer was organized. Alien means organized under the law of another country, foreign under the law of another state, and domestic under Texas law. A company from another American state would be foreign rather than alien, which is the common trap. An out-of-state American company would be foreign.

76. B — An appointment is separate from a license. The insurer files notice of appointment with the Department, and only then may the agent sell for that insurer, so selling without an appointment on file violates the Code regardless of the license held or the insurer's admitted status. Appointment and license are separate requirements entirely.

77. D — The death benefit limit is three hundred thousand dollars per individual life, aggregating all policies with that insurer. Because one hundred eighty thousand falls under that cap, the whole amount is covered rather than being reduced. The limit operates as a ceiling rather than as a fixed payout. Limits apply per life rather than per policy.

78. A — Using the existence of the Association to induce a purchase is prohibited in any form. Presenting it as a safety net encourages consumers to disregard an insurer's financial strength, which is exactly the judgment the market depends on them exercising when comparing competing companies. Financial strength is the judgment consumers must exercise.

79. B — Texas requires a grace period of at least one month for every premium after the first, and where expressed in days rather than as a month, at least thirty-one days must be granted. The policy remains in full force throughout, with any overdue premium deducted from a death settlement. One month is the alternative statutory formulation.

80. D — A Texas life policy in force for two years during the insured's lifetime is incontestable except for nonpayment of premiums. At thirty-four months that period has long run, so the insurer may no longer contest for application misstatements however material the misstatement proves to be. Nonpayment of premium remains separately excepted.

81. C — Texas requires loans to be made available after premiums for three full years have been paid and a cash value is available, so a request at twenty-six months falls short of the statutory condition. Term life and pure endowment policies are exempt from the requirement altogether. Term and pure endowment contracts stay exempt.

82. A — Misstatement of age is a proportionality remedy applied whether the age was understated or overstated. The amount payable is adjusted to what the premium actually paid would have purchased at

the correct age, the policy is not voided, and no fraud need be established for that. Overstated age produces the identical adjustment.

83. C — The governing standard judges an advertisement by the overall impression it creates rather than by whether each statement is literally accurate. Arrangement, emphasis, and omission can leave a reasonable consumer with a false impression, and a buried disclaimer does not cure that failure. Emphasis and omission can mislead by themselves.

84. A — The fifteen calendar day free look is triggered by failure to provide the Buyer's Guide and required disclosure document at or before application. Where both are delivered on time that trigger never operates, and the contract's own provision governs the period instead of the rule. Timely delivery of both documents avoids the trigger.

85. D — Replacement reaches coverage that is terminated, lapsed, surrendered, reduced in value, or converted to paid-up or extended term in connection with a new purchase. A lapse arranged to fund the new premium is squarely within that definition, so the notice and documentation duties attach. Nothing is surrendered, yet the duties still attach.

86. B — 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 conservation, and it lets the applicant decide with both positions in front of them. The applicant then weighs both positions together.

87. B — The Standard Nonforfeiture Law prescribes minimum values and requires a table of guaranteed values in the policy. That printed table makes the guarantee enforceable rather than theoretical, and an insurer may exceed the statutory minimum but may never fall below the schedule it printed. The printed table makes the guarantee enforceable.

88. D — 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 window closes. The window closes and does not reopen later.

89. C — Credit life pays the creditor the balance of the debt if the debtor dies, so the amount of insurance may not exceed the indebtedness and coverage decreases as the loan amortizes. Credit insurance may also not lawfully be made a condition of obtaining the loan itself. Creditor control over the transaction explains the rule.

90. A — 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 afterward. Notification and premium sustain coverage afterward.

91. C — A Medicare supplement policy may not be canceled or non-renewed on the ground of health status, claims experience, or age. Nonpayment of premium and material misrepresentation remain

legitimate grounds, and that restriction is exactly what makes the coverage dependable for an aging population. Guaranteed renewability is the practical value bought.

92. D — 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 or inferred in underwriting. Inference about a person's life is never permitted.

93. B — Forty-nine employees falls inside the Texas small employer band of two to fifty, so guaranteed issue applies and the carrier must issue any plan it offers regardless of health status or claims history. Rating is constrained, so refusal by price is equally unavailable to the carrier. Refusal and prohibitive pricing are equally unavailable.

94. A — Guaranteed issue does not mean issue on any terms. A carrier may impose minimum participation and minimum employer contribution requirements and may decline an employer failing them, because both prevent adverse selection. The decline rests on the arrangement rather than on anyone's health status. Health status can never justify the decline.

95. D — Required preventive services must be covered without cost sharing when delivered by a network provider, which is why a routine screening ordinarily produces no bill. A diagnostic test ordered to investigate an existing symptom is a different service and may attract normal deductible and coinsurance. Purpose of the test rather than its type decides.

96. B — Where a state does not establish its own exchange, a federally facilitated exchange operates there, and Texas uses the federal Marketplace. Plans sold through it are grouped into metal tiers reflecting actuarial value, meaning the share of expected costs the plan pays rather than clinical quality. Actuarial value rather than quality is described.

97. C — 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 higher tier means lower cost sharing for the member and nothing beyond that. Cost sharing alone is what the tier communicates.

98. A — An HMO issues an evidence of coverage setting out the services an enrollee is entitled to, the conditions attached, and the enrollee's rights, and it must be approved by the Department before use. Insurers issue policies, and group insurers issue certificates under a master contract. Departmental approval precedes any use of it.

99. A — 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 for the HMO to act upon. Geography rather than health justifies the nonrenewal.

100. D — Emergency care must be covered without regard to network status, because an enrollee facing an emergency has no meaningful opportunity to select a participating provider. Texas also addresses

what an enrollee may be billed where an out-of-network provider treated them at an in-network facility. Absence of genuine choice triggers the protection.

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

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

103. A — A change of address must be reported to the Department in writing within thirty days, and telling an appointing insurer does not satisfy that separate obligation. Felony convictions and administrative action by another authority must also be reported, and failing to report is itself a disciplinary ground. Each reporting obligation stands entirely on its own.

104. C — The Commissioner enforces the Insurance Code and adopts rules implementing it, and may examine records, investigate, hold hearings, impose penalties, and issue cease and desist orders. Enacting, amending, and repealing statutes are legislative functions the office cannot perform on its own authority. Rules implement statutes rather than creating them outright.

105. 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, a small amount, nor the absence of selling activity makes payment to an unlicensed person lawful. Licensing cannot be circumvented by paying an intermediary.

106. 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 is lawful underwriting, so the violation lies in treating equivalent risks differently rather than in rating at all. Equivalent risks must receive equivalent treatment throughout.

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

108. D — Basic hospital, medical-surgical, and major medical coverage carries a five hundred thousand dollar limit per individual, the highest of the categories. Long-term disability and long-term care are limited to three hundred thousand, and other supplemental health such as Medicare supplement to two hundred thousand. Each coverage tier carries its own distinct statutory limit.

109. B — Using the existence of the Association to induce a purchase is prohibited in any form. Presenting it as a safety net encourages consumers to disregard an insurer's financial strength, which is

exactly the judgment the market depends on them exercising when choosing between competing companies. Financial strength is the judgment consumers must exercise.

110. A — The policy may provide for an interest charge on the unpaid premium during the grace period, and where it does the rate must be specified in the contract. The policy may also stipulate that an overdue premium is deducted from any settlement if death occurs during that period. Specification of the rate is the governing condition.

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

112. D — Term life and pure endowment policies are not required to provide loans even where they happen to generate cash values, because the requirement attaches to the type of policy rather than to the presence of value. Permanent forms must offer loans after premiums for three full years. Value alone does not create the borrowing entitlement.

113. A — The Buyer's Guide explains life insurance in general terms while the policy summary sets out the specific contract's premiums, benefits, and values. Both are delivery requirements attached to the sale, and together they allow a buyer to compare competing products on a common basis. Comparison on a common basis is the shared purpose.

114. B — Illustrations must clearly distinguish guaranteed from non-guaranteed elements, and presenting a projection as though it were guaranteed is a misrepresentation whatever the footnotes may state. A signed acknowledgment does not cure a spoken statement that misleads the prospect at the point of sale. Footnotes cannot cure a misleading spoken statement.

115. C — The replacing agent determines whether replacement is involved by asking the applicant, presents the required notice, obtains signatures, submits a statement identifying the coverage replaced, and provides copies of sales material used. The existing insurer's consent is never required for the transaction to proceed. Documentation makes the recommendation reviewable afterward.

116. B — The Standard Nonforfeiture Law prescribes minimum values and requires a table of guaranteed values showing benefits available at the end of a series of years. That printed table makes the guarantee enforceable rather than theoretical, and an insurer may exceed those values but never breach them. An insurer may exceed but never breach the schedule.

117. D — 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 window closes. Attained age pricing reflects her current age instead.

118. A — Credit insurance may not lawfully be made a condition of obtaining the loan, because the creditor controls the transaction and the risk of pressure on the borrower is real. Naming the creditor as

beneficiary and limiting the amount to the indebtedness are, by contrast, normal features. Creditor control over the transaction explains the rule.

119. B — 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 and additional premium for coverage to continue beyond the initial period. Notification and premium sustain coverage beyond that period.

120. D — A Medicare supplement purchaser may return the policy within thirty days of receiving it and obtain a full refund of premium with no questions asked. Twenty-nine days falls inside that window, and certified mail preserves proof of timely return because the burden falls on the consumer. Certified mail preserves proof of a timely return.

121. C — An insurer may not use sexual orientation in underwriting and may not use marital status, occupation, living arrangements, or similar proxies to infer it. Underwriting must rest on documented medical evidence of a condition rather than on inference about how a person lives. Medical evidence rather than inference must govern underwriting.

122. A — 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 regardless of coverage. Historic exclusion is what prompted the mandate originally. Untreated dependency generates costs elsewhere in the plan anyway.

123. C — The Texas small employer framework has long operated on a band of two to fifty eligible employees, so fifty-three sits outside it. Employers above the band are large employers for these purposes and fall outside the small employer protections, including guaranteed issue and constrained rating. Larger employers negotiate on ordinary commercial terms instead.

124. A — 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 opportunistic exit when a block turns unprofitable. Opportunistic exit and swift return are both prevented.

125. D — Cost-sharing reductions lower deductibles, copayments, and coinsurance for eligible enrollees and are available only with a plan at the designated tier. The premium tax credit is a separate support with different eligibility that reduces monthly premiums, and treating the two interchangeably misleads clients. The two supports carry entirely different eligibility rules.

126. B — Non-grandfathered individual and small group plans must cover essential health benefits across defined categories, and the outline draws attention to mental health and substance use disorder services, pediatric services, and preventive services. Adult dental, custodial care, and cosmetic procedures fall outside the required categories. Those three categories are the ones specifically named.

127. C — Applicable large employers must report on the coverage they offer and may face payments where they do not offer coverage meeting the required standard. All employers must notify employees

of the Marketplace, and the agent's role is ensuring the employer knows those obligations exist. Agents ensure the employer knows the obligations exist.

128. B — Fraud, material misrepresentation, nonpayment of premium, and permanent relocation outside the service area are all legitimate grounds for cancellation or nonrenewal. Health status, volume of services used, and complaints filed with the Department are never permissible grounds for an HMO to act. Health status is never a permissible ground at all.

129. A — Texas provides mechanisms addressing what an enrollee may be billed where an out-of-network provider treated them at an in-network facility without genuine choice. Emergency care rests on identical reasoning, that the absence of any real opportunity to choose is what triggers the protection. Emergency care rests on precisely identical reasoning.

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