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Virginia Life, Annuities, and Health Insurance Examination Series 11-01

Insurance Licensing Virginia-Life-Annuities-and-Health-Insurance

Version Demo

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QUESTION NO: 1

The purpose of the Rules Governing Standards for Medicare Supplement Policies is to:

A. Provide guaranteed coverage that duplicates Medicare

B. Provide coverage for Accident and Sickness Insurance to individuals of Labor Unions

C. Ensure no Medicare Supplement policy or certificate contains limitations and exclusions of coverage

D. Provide full disclosure in the sale of Accident and Sickness Insurance to persons eligible for Medicare

ANSWER: D

Explanation:

The purpose is to “Provide full disclosure in the sale of Accident and Sickness Insurance to persons eligible for Medicare.” Virginia’s Medicare supplement insurance rules expressly state that their purpose is to provide standards for Medicare supplement policies and certificates and to protect persons eligible for Medicare through full disclosure in the sale of accident and sickness insurance policies or certificates marketed as Medicare supplements. Full disclosure helps Medicare-eligible consumers understand the policy’s benefits, limitations, premium, and relationship to Medicare before making a purchasing decision. This consumer-protection purpose is especially important because Medicare supplement coverage is designed to work alongside Original Medicare by helping pay certain deductibles, coinsurance, and copayments; it is not intended to replace Medicare or duplicate benefits indiscriminately. The rules also establish requirements for policy standards, advertising, applications, and disclosures so sales are conducted in a clear, fair, and informed manner. Virginia’s regulation is available through the Virginia Administrative Code at 14VAC5-170, Rules Governing Standards for Medicare Supplement Policies. For consumer context on how Medigap policies supplement Original Medicare, see Medicare.gov: Get ready to buy Medicare Supplement Insurance.

QUESTION NO: 2

A life insurance beneficiary elects a settlement option under which the insurer retains the policy proceeds and pays interest to the beneficiary at regular intervals. What happens to the policy's principal amount under this option?

A. It remains with the insurer while interest is paid to the beneficiary.

B. It is paid immediately in equal monthly installments.

C. It is forfeited to the insurer when the beneficiary begins receiving interest.

D. It is converted automatically into additional term life insurance.

ANSWER: A

Explanation:

Under the interest-only settlement option, the insurer retains the principal proceeds and pays the interest earnings to the beneficiary. The principal remains with the insurer until it is paid to a designated recipient or distributed under the terms selected by the policyowner or beneficiary. This differs from a fixed-period option, which distributes both principal and interest over a stated period, and a life-income option, which bases payments on the annuitant's life expectancy. Interest-only payments therefore do not ordinarily reduce the principal amount being held.

QUESTION NO: 3

An insurance company writing business in a state other than the one in which it is domiciled is called:

A. A foreign insurer

B. A domestic insurer

C. An alien insurer

D. A captive insurer

ANSWER: A

Explanation:

A foreign insurer is correct because an insurer's classification as domestic or foreign is determined from the perspective of the state in which it is conducting insurance business. A company is domestic in the state under whose laws it was formed and incorporated. When that same company is authorized to transact insurance in another U.S. state, it is a foreign insurer in that other state. For example, an insurer incorporated in Virginia is domestic in Virginia; if it obtains authority to sell insurance in Maryland, Maryland treats it as a foreign insurer. The term identifies the insurer's state of organization relative to the state applying its insurance laws; it does not describe where the company sells policies generally or the residence of its policyholders. Virginia law expressly defines a foreign insurance company as one organized under the laws of a state other than Virginia. This terminology is important for producer licensing and insurer regulation because an insurer must receive the appropriate certificate of authority before transacting insurance in a jurisdiction. See Virginia Code § 38.2-100, available from the Virginia Legislative Information System, and the National Association of Insurance Commissioners' state insurance department directory for state insurance regulatory resources.

QUESTION NO: 4

(The owner's cost basis in a non-qualified deferred annuity is usually equal to the:)

A. Opportunity cost

B. Total premiums paid

C. Guaranteed cash value

D. Actual cash value

ANSWER: B

Explanation:

Total premiums paid is correct because an owner's cost basis in a non-qualified deferred annuity is generally the owner's investment in the contract—the after-tax money contributed through premium payments. Unlike a qualified retirement annuity, contributions to a non-qualified annuity ordinarily are not deductible when paid. Therefore, the premiums establish the amount that has already been taxed and that may generally be recovered without being taxed again.

This basis is important when the contract is distributed or annuitized. Earnings accumulate on a tax-deferred basis while they remain in the annuity. When a non-annuitized withdrawal occurs, tax rules generally treat earnings as coming out first, so the taxable portion is ordinarily taxed as ordinary income. When periodic annuity payments begin, each payment is divided between a tax-free recovery of investment in the contract and taxable earnings using an exclusion ratio. The owner's investment in the contract can be adjusted if there have been prior tax-free recoveries, refunds, or certain other contract transactions, which is why the question appropriately says "usually." IRS guidance describes the investment-in-the-contract concept and the taxation of annuity distributions in IRS Publication 575, Pension and Annuity Income and IRS Topic No. 410, Pensions and Annuities.

QUESTION NO: 5

Who has the right to change the beneficiary of a health policy with a revocable beneficiary designation?

A. The policyowner

B. The beneficiary

C. The insurer

D. The agent

ANSWER: A

Explanation:

The policyowner has the right to change a beneficiary designation when that designation is revocable. A revocable beneficiary has an expectancy in the policy proceeds but no vested right that prevents the policyowner from exercising ownership rights. Consequently, the policyowner may replace the named beneficiary, add or remove beneficiaries, or revise the proportions payable to beneficiaries, subject to the policy's required change procedure. Usually, this requires a written request on the insurer's form or through another insurer-approved process; the change is generally effective according to the policy terms once the request is properly made or recorded. The policyowner's control is the defining feature of a revocable designation and continues unless the policyowner elects to make a beneficiary designation irrevocable. Beneficiary designations are a standard policy provision topic in Virginia's Life and Health examination content outline. The Virginia Bureau of Insurance provides consumer and regulatory information about insurance policies and policyholder rights at Virginia SCC Bureau of Insurance. Virginia insurance statutes, including provisions administered by the Bureau, are available through the Code of Virginia, Title 38.2.

QUESTION NO: 6

All of the following are dividend options in life insurance policies EXCEPT:

A. Applying the dividends to reduce the premium due

B. Using the dividends to purchase additional paid-up life insurance

C. Accumulating the dividends with interest

D. Receiving the entire policy cash value

ANSWER: D

Explanation:

Receiving the entire policy cash value is the exception because it is a policy-surrender transaction, not a dividend election. Cash value is the accumulated value available under a permanent life insurance policy and is generally paid when the owner elects to surrender the contract. Surrender ends the insurance coverage and requires the insurer to pay the applicable surrender value under the policy's nonforfeiture provisions. A dividend, in contrast, is a return of divisible surplus paid or credited under a participating life policy; it does not represent the policy's entire accumulated cash value. Virginia's required provisions for participating life insurance address how dividends are apportioned and made available to policyowners, distinguishing dividends from the contract's cash-surrender benefit. The distinction matters for exam purposes: dividend elections concern the disposition of the insurer's declared policy dividend while the policy remains in force, whereas electing to receive the entire policy cash value is an exercise of the owner's right to terminate the policy for its surrender value. See Virginia Code § 38.2-3207 and the Virginia SCC's Bureau of Insurance consumer resources.

QUESTION NO: 7

Which of the following statements regarding the renewal of a Medicare supplement policy is in accordance with Virginia regulations?

A. Each policy is guaranteed to be renewable.

B. Each policy is subject to an annual administrative fee to be paid prior to renewal.

C. An individual must obtain an annual physical which meets specific health requirements to have the policy renewed.

D. An individual has the option to renew the policy as long as the maximum annual coverage has not been met the previous year.

ANSWER: A

Explanation:

Each policy is guaranteed to be renewable. Under Virginia's Medicare supplement insurance requirements, a Medicare supplement policy or certificate must be guaranteed renewable. This protection means that renewal is not conditioned on the insured continuing to satisfy health underwriting standards, remaining claim-free, or staying below a stated annual benefit amount. The guaranteed-renewable requirement is especially important because Medicare supplement coverage is designed to help beneficiaries meet Medicare deductibles, coinsurance, copayments, and other covered gaps that may become more significant as health needs change. Virginia law permits termination only in limited circumstances specified by statute, including nonpayment of premium or material misrepresentation. Thus, an insurer cannot decline renewal merely because the insured's health has deteriorated or because the insured has submitted claims. The insurer may continue to adjust premiums for an entire class of similarly situated insureds when permitted, but the individual policyholder retains the contractual right to renew as long as the applicable premium is paid and no permitted ground for termination exists. See the Virginia Medicare supplement policy standards in Virginia Code § 38.2-3611 and consumer information from the Virginia State Corporation Commission.

QUESTION NO: 8

An insured died six months after a life insurance policy was issued. The full death benefit will NOT be paid if the cause of death was:

A. Accidental injury

B. Lung cancer

C. Suicide

D. Heart attack

ANSWER: C

Explanation:

Suicide is correct because Virginia permits an individual life insurance policy to contain a suicide limitation for a death occurring within two years after the policy's issue date. Since the insured died only six months after issuance, the death falls within that permitted exclusion period. When an applicable suicide provision is in the policy, the insurer's liability is limited rather than requiring payment of the policy's full face amount; under Virginia law, the insurer must pay at least the premiums paid on the policy. The specific policy contract controls the precise wording and any amount payable, but the examination principle is that suicide during the early-policy suicide exclusion period can prevent payment of the full death benefit. This rule allows insurers to limit liability for a death by suicide during the first two policy years while preserving a minimum return of premiums. Virginia's governing statute authorizes this restriction and defines its maximum duration. See Virginia Code § 38.2-3106. For the broader statutory framework governing life insurance policies in Virginia, consult Virginia Code, Chapter 31: Life Insurance.

QUESTION NO: 9

In HMO coverage, preventive services include:

A. Rehabilitation therapy

B. Treatment for alcoholism

C. Childhood immunizations

D. Home health services

ANSWER: C

Explanation:

Childhood immunizations are preventive services because they are provided to prevent illness before it occurs, rather than to restore function or provide care after a condition has developed. Vaccines administered during childhood protect against specified communicable diseases and are a core example of primary preventive care. In an HMO model, covered services

are designed not only to treat members when they are sick, but also to promote health maintenance through routine preventive care. Virginia's statutory framework for health maintenance organizations identifies preventive health services as part of the health-care-service concept applicable to HMOs; see the Virginia HMO provisions at Virginia Code, Chapter 43. In addition, federal preventive-care guidance recognizes immunizations as recommended preventive services. Health plans must generally cover, without member cost sharing when delivered under applicable plan rules, immunizations recommended by the Advisory Committee on Immunization Practices. The federal government's consumer guidance specifically includes vaccines among preventive services at HealthCare.gov: Preventive health services. Therefore, childhood immunizations fit the meaning of preventive services in HMO coverage.

QUESTION NO: 10

In initiating a health insurance claim, what must the insured provide to the insurer within the time limit specified in the policy or as soon thereafter as reasonably possible?

A. Copies of medical bills

B. Verification of coverage

C. Physician's diagnosis

D. Notice of claim

ANSWER: D

Explanation:

Notice of claim is correct because it is the initial communication from the insured, or someone acting for the insured, that alerts the insurer that a covered loss has occurred or that services giving rise to a claim have begun. Virginia's required health insurance policy provisions state that written notice of claim generally must be given within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as reasonably possible. The notice is directed to the insurer or another party identified in the policy, such as the insurer's authorized agent, and must provide enough information to identify the insured. It does not need to include the complete substantiation of the loss at this early stage. After receiving notice, the insurer supplies the forms customarily used for filing proof of loss. The claimant then submits the more detailed proof required to establish the claim, ordinarily within the policy's stated proof-of-loss period. This sequence allows the insurer to open and begin handling the claim promptly while giving the insured a practical opportunity to provide full documentation. See Virginia Code § 38.2-3542 at Virginia Legislative Information System and the Virginia SCC Bureau of Insurance's insurance consumer resources.

QUESTION NO: 11

To determine whether unfair trade practices have been violated, who has the power to examine a licensee's books and records?

A. The Bureau of Insurance

B. The National Association of Insurance Commissioners

C. The Federal Deposit Insurance Corporation

D. The Virginia Insurance Guaranty Association

E. The State Corporation Commission

ANSWER: E

Explanation:

The State Corporation Commission has the statutory authority to examine and investigate the affairs of persons engaged in the insurance business when determining whether an unfair method of competition or unfair or deceptive act or practice has occurred. Virginia's Unfair Trade Practices Act expressly gives this examination and investigation authority to the

Commission. That authority includes access to the relevant books, accounts, records, documents, and other information needed to determine compliance with Virginia insurance law. The Commission may conduct the examination directly or act through appropriately authorized personnel in administering and enforcing the insurance laws. In practical terms, the Bureau of Insurance is the insurance-regulatory division within the State Corporation Commission and performs important regulatory and examination work; however, the legal examination power described in the statute is vested in the State Corporation Commission. For an insurance licensing examination, the statutory designation controls the answer. See Virginia Code § 38.2-510, available through the Virginia Legislative Information System, and the Virginia State Corporation Commission Bureau of Insurance regulatory information page.

QUESTION NO: 12

Under which one of the following life insurance policies does the protection extend to age 100, while the premiums are paid for a shorter period of time?

A. Endowment

B. Continuous premium whole life

C. Limited payment whole life

D. Yearly renewable term

ANSWER: C

Explanation:

Limited payment whole life is designed to provide permanent whole life insurance protection—traditionally described in licensing materials as extending to age 100—while requiring premiums for only a specified, shorter payment period. Common designs include 10-pay life, 20-pay life, or life paid up at age 65. The policyowner pays a higher premium during that limited period because the full cost of lifetime coverage is being funded sooner. Once the required premium-paying period ends, the policy becomes paid up: the insured's coverage remains in force and no additional premiums are due, provided the policy has not been surrendered or otherwise terminated. Like other forms of whole life insurance, limited-payment whole life generally has level death-benefit protection and builds cash value according to the contract's guarantees. This combination of permanent protection and an accelerated premium schedule is the defining feature tested by the question. The Virginia State Corporation Commission's Bureau of Insurance regulates life insurance in the Commonwealth; see its insurance consumer and regulatory information. For general consumer guidance on permanent life insurance and cash-value policies, see the NAIC's Life Insurance resource.

QUESTION NO: 13

The interest that an insurance company earns on life insurance premiums paid helps to:

A. Increase the life insurance premium rate

B. Increase the mortality rate

C. Decrease the life insurance premium rate

D. Decrease the mortality rate

ANSWER: C

Explanation:

Decrease the life insurance premium rate is correct because interest is one of the fundamental elements used in determining life insurance premiums, along with mortality and insurer expenses. Insurers receive premiums before many death claims become payable. They invest those funds, subject to their contractual obligations and applicable investment requirements, and the investment income earned becomes part of the resources available to meet future policy benefits. Because anticipated interest earnings help fund those benefits, the insurer does not need to collect the entire expected cost of coverage, expenses, and claim payments solely through premium charges. All else being equal, a higher assumed interest

rate therefore supports a lower gross premium; conversely, lower anticipated investment earnings can create pressure for higher premiums. This pricing relationship is especially important in long-duration life insurance contracts, where premiums may be invested for many years before a death benefit is paid. The National Association of Insurance Commissioners describes life insurance policies as contracts providing a death benefit and identifies insurers' investment activities as a key component of their financial operations. The Virginia Bureau of Insurance regulates insurers and provides consumer and licensing information relevant to life insurance in the Commonwealth. See the NAIC Life Insurance Consumer Guide and the Virginia State Corporation Commission Bureau of Insurance.

QUESTION NO: 14

Group credit life insurance is generally a form of:

A. Decreasing term insurance

B. Increasing term insurance

C. Level term insurance

D. Whole life insurance

ANSWER: A

Explanation:

Group credit life insurance is generally structured as decreasing term insurance because its purpose is to pay off a borrower's unpaid debt if the borrower dies during the loan term. The amount of insurance is tied to the outstanding indebtedness rather than to a fixed personal protection amount. As the borrower makes scheduled loan payments, the remaining balance normally declines; the amount payable under the credit life coverage correspondingly declines. This design helps ensure that the creditor receives an amount sufficient to satisfy the covered loan balance at the time of death, subject to the policy's terms and applicable limits.

Virginia law defines credit life insurance as insurance on the life of a debtor in connection with a specific loan or other credit transaction, with benefits payable to the creditor to reduce or extinguish the debtor's obligation. That statutory purpose supports the decreasing-benefit structure used for group credit life coverage. It is term insurance because the coverage is intended to last only for the duration of the underlying credit obligation, not for the insured's entire lifetime. See Virginia Code § 38.2-1600 and the Virginia Bureau of Insurance's Insurance consumer resources.

QUESTION NO: 15

Disability income insurance policies usually provide coverage for loss of income resulting from:

A. Self-inflicted injuries

B. Injuries incurred while in military service

C. Disability resulting from war

D. Accidental injuries

ANSWER: D

Explanation:

Accidental injuries is correct because disability income insurance is designed to replace a portion of an insured person's earned income when a covered injury prevents that person from working. A disability may be caused by either an accident or sickness, subject to the policy's definitions, benefit triggers, elimination period, and other contract terms. Thus, an accidental injury that causes a qualifying loss of time from work is a core risk addressed by disability income coverage. Benefits are generally payable periodically, such as weekly or monthly, after the insured satisfies the policy's waiting period and establishes that the injury meets the policy definition of disability. The precise amount and duration of benefits depend on the selected policy provisions, including the benefit period and whether the contract uses an own-occupation or other disability

standard. Virginia's insurance statutes recognize accident and sickness insurance as coverage for losses resulting from bodily injury, sickness, or related causes, which supports the fundamental role of accident-caused disability in this type of policy. See Virginia Code § 38.2-3500 and the Virginia State Corporation Commission Bureau of Insurance.

QUESTION NO: 16

Pre-existing conditions include conditions of health that:

A. Are never insurable under any circumstances or degree of severity

B. Must exist before an applicant can be accepted by an insurer

C. Have been medically treated or diagnosed prior to the effective date of coverage

D. Develop after the effective date of the policy but before the expiration of the time limit on certain defenses

ANSWER: C

Explanation:

Have been medically treated or diagnosed prior to the effective date of coverage is correct because a pre-existing condition is generally a sickness, injury, or other health condition for which the insured received medical advice, diagnosis, care, or treatment before the health coverage became effective. This concept permits insurers to identify health conditions that were already present and known or treated before the new policy began. Whether a policy may impose a pre-existing-condition exclusion, and the permitted scope or duration of any exclusion, depends on the type of coverage and applicable state and federal law. For Virginia individual accident and sickness insurance, policy provisions and exclusions must comply with Virginia insurance statutes and regulations. The operative point in the definition is the connection between the condition and medical diagnosis or treatment before the policy's effective date; it does not mean that the condition can never be insured. Review the Virginia Bureau of Insurance's accident and sickness insurance laws in Code of Virginia, Chapter 35 and Virginia's official insurance-agent examination materials at PSI Test Takers.

QUESTION NO: 17

Policy loan provisions may be found in all of the following life insurance policies EXCEPT:

A. Twenty payment life

B. Five year life

C. Whole life

D. Universal life

ANSWER: B

Explanation:

Five year life is correct because it describes short-duration term life insurance, which is designed to provide a death benefit for a specified five-year period rather than to build policy cash value. A policy loan is an advance from the insurer that is secured by the policy's accumulated cash value. Because this type of coverage generally has no cash-surrender value or other accumulated reserve available to the owner during its term, there is no value against which the insurer can make a policy loan. The availability of a loan is therefore tied to cash-value life insurance, not merely to the fact that a contract provides life insurance protection. If a policy loan is outstanding under a cash-value policy, interest accrues and the loan balance, including accrued interest, reduces the amount payable when the policy is surrendered or when a death benefit becomes due. Virginia's required-provisions statute addresses policy-loan terms for applicable life insurance contracts, including the treatment of loan interest and the effect of indebtedness. See Virginia Code § 38.2-3305. For a consumer-oriented discussion of the distinction between term coverage and cash-value permanent life insurance, see the National Association of Insurance Commissioners life insurance guide.

QUESTION NO: 18

(If Kim applies for a life insurance policy on Kim's own life and names Chris to receive the death benefit:)

A. Kim is the insured and the beneficiary

B. Kim is the policyowner and the applicant

C. Chris is the policyowner and the insured

D. Chris is the applicant and the beneficiary

ANSWER: B

Explanation:

Kim is the policyowner and the applicant because Kim is the person submitting the application for life insurance and, absent facts showing a different ownership arrangement, the applicant becomes the policyowner when the insurer issues the policy. The policyowner holds the contractual rights under the policy, such as paying premiums, naming or changing a beneficiary when the designation is revocable, selecting policy options, and exercising applicable policy values or settlement rights. Kim also is the insured because the coverage is written on Kim's life, while Chris's stated role is to receive the death benefit upon the insured's death. The key point tested is that a single person can occupy more than one policy role: an individual who seeks coverage on their own life ordinarily is both the applicant and the policyowner, as well as the insured. Virginia recognizes life insurance as insurance on human lives, and the policy structure distinguishes the insured life from the person entitled to policy rights and the person designated to receive proceeds. See the Virginia insurance statutes at Virginia Code, Title 38.2, Chapter 31 and the consumer overview from the National Association of Insurance Commissioners.

QUESTION NO: 19

Which contract provides an income benefit until the first of two annuitants dies?

A. A joint and survivor annuity

B. A temporary annuity

C. A joint life annuity

D. A single life annuity

ANSWER: C

Explanation:

A joint life annuity provides periodic income based on the lives of two annuitants and is structured to end when the first annuitant dies. This arrangement uses a "first death" measure: both individuals must be alive for payments to continue, so the death of either person terminates the annuity income. It is commonly selected when income is needed only while both named people are living, rather than to protect a surviving annuitant after the other person's death.

In annuity terminology, the number of covered lives and the point at which payments stop are essential contract features. A joint life payout is therefore distinct in its defining rule that the income period is limited to the joint lifetime of the two annuitants—that is, the period ending at the first death. Virginia regulates annuity contracts within its insurance laws, including provisions addressing annuities and required policy standards. See the Virginia Legislative Information System's annuity provisions at Virginia Code, Chapter 31. For a general consumer-oriented discussion of annuity payout choices and life-contingent income, see the National Association of Insurance Commissioners' annuity guide.

QUESTION NO: 20

Which life insurance policy provision has the potential to reduce the death benefit?

A. Accelerated benefit

B. Disability premium waiver

C. Spendthrift clause

D. Conversion privilege

ANSWER: A

Explanation:

Accelerated benefit is correct because it permits an insured who meets the policy's qualifying conditions—commonly a terminal illness, chronic illness, or another specified severe condition—to receive part of the policy's death benefit during life. The payment is an advance against the amount otherwise payable at death, rather than an additional benefit layered on top of the policy's face amount. Consequently, the amount paid early, along with any applicable interest or administrative charges specified by the contract, is reflected in the remaining proceeds available to the beneficiary. This is why an accelerated-benefit provision has the potential to reduce the death benefit ultimately paid under the life insurance policy. The precise eligibility requirements, maximum advance, effect on cash values or loans, and calculation of the residual death benefit are controlled by the individual policy and applicable insurance requirements. In Virginia, life insurance policy provisions are regulated under Chapter 33 of Title 38.2 of the Virginia Code. The NAIC's Accelerated Benefits Model Regulation likewise describes accelerated benefits as benefits payable during the insured's lifetime from the life insurance policy's death benefit. See the Virginia Code, Title 38.2, Chapter 33 and the NAIC Accelerated Benefits Model Regulation.

QUESTION NO: 21

Ambulatory care centers are most often used by patients who require:

A. Physical therapy

B. Wellness centers

C. Outpatient surgical procedures

D. Overnight accommodations

ANSWER: C

Explanation:

Outpatient surgical procedures is correct because ambulatory care is furnished without an expected overnight hospital admission. An ambulatory surgical center is specifically organized to provide surgical services to patients who arrive for a planned procedure, receive preoperative, operative, and recovery care, and are discharged the same day once clinically stable. These settings commonly support procedures that do not generally require inpatient hospitalization, such as endoscopy, cataract surgery, minor orthopedic procedures, and similar scheduled interventions. The essential insurance-exam distinction is that the care is outpatient and procedure-oriented: the patient is treated and released rather than admitted for an extended stay. Virginia's regulations define an ambulatory surgical center as a facility that provides surgical services on an outpatient basis, which directly supports identifying outpatient surgery as its principal use. See the Virginia Administrative Code's ambulatory surgical center requirements at 12VAC5-410-10. Federal Medicare guidance likewise describes ambulatory surgical centers as facilities that furnish surgical services to patients who do not require hospitalization, reinforcing the same-day outpatient purpose. See CMS Ambulatory Surgical Centers.

QUESTION NO: 22

In a noncancelable disability income policy:

A. The premium cannot be increased above the schedule specified in the policy

B. The premium can be increased at the insurer's will

C. The insured has no renewal rights

D. The insurer can refuse to renew the policy

ANSWER: A

Explanation:

The premium cannot be increased above the schedule specified in the policy is correct because noncancelable disability income coverage gives the insured two contractual protections for the stated noncancelable period: guaranteed renewal and a guaranteed premium rate. Provided the policyowner pays premiums when due and complies with the policy's terms, the insurer must continue the coverage and cannot individually cancel it or raise its premium. The rate is fixed as stated in the contract, commonly through a specified age, such as age sixty-five, although the precise duration is determined by the policy language.

This feature is especially important in disability income insurance because a change in the insured's health, occupation, or claims experience after issue does not allow the insurer to increase that insured's premium during the noncancelable period. Virginia's accident and sickness insurance regulations set standards for policy renewability provisions and the use of noncancellable terminology, helping ensure that such contractual guarantees are presented consistently. See the Virginia Administrative Code provisions on accident and sickness insurance policy standards at 14VAC5-170 and Virginia's insurance statutes at Code of Virginia, Chapter 35.

QUESTION NO: 23

If an individual's occupation is considered to be illegal:

A. It must be stated as such on a health insurance application.

B. It may require a waiver on a disability income insurance policy.

C. It may result in a denial of a disability income claim.

D. It results in a substandard rating on a health insurance policy.

ANSWER: C

Explanation:

"It may result in a denial of a disability income claim." is correct because disability income coverage is designed to insure losses arising from covered sicknesses and injuries, subject to the policy's exclusions and provisions. An illegal-occupation provision allows an insurer to deny a loss when the insured's engagement in an illegal occupation is a contributing cause of the disability or loss. The key point is that denial is not automatic merely because a person has an unlawful occupation; the applicable policy provision and the connection between that activity and the claimed loss matter. Therefore, "may result" accurately states the effect of illegal occupation on a disability income claim. Virginia regulates accident and sickness insurance, including policy provisions and required policy forms, under Chapter 35 of Title 38.2 of the Code of Virginia. The National Association of Insurance Commissioners' model standards also recognize illegal occupation as a policy provision that may limit an insurer's liability for a covered loss. See the Code of Virginia, Title 38.2, Chapter 35 and the NAIC Uniform Individual Accident and Sickness Policy Provisions Model Act.

QUESTION NO: 24

In long-term care insurance, ADLs normally include:

A. Age, sex, income, and occupation

B. Physicians, surgeons, dentists

C. Spouse, children, parents, and siblings

D. Dressing, eating, bathing, and transferring

ANSWER: D

Explanation:

Dressing, eating, bathing, and transferring are core activities of daily living used in long-term care insurance to measure whether an insured needs substantial assistance with basic personal-care tasks. “Transferring” generally means moving into or out of a bed, chair, or wheelchair without help. These activities are central to the benefit-trigger standards in qualified long-term care coverage because an individual’s inability to perform a specified number of daily living activities, or the presence of severe cognitive impairment, can establish eligibility for benefits. Virginia’s long-term care insurance rules define activities of daily living to include bathing, continence, dressing, eating, toileting, and transferring. Therefore, the listed set of dressing, eating, bathing, and transferring consists entirely of recognized daily living activities, even though it does not list every activity commonly included in the full definition. The insurer’s policy must state its benefit eligibility criteria and cannot use a more restrictive definition of these activities than Virginia’s applicable standards. See the Virginia long-term care insurance regulation’s definitions at 14VAC5-200-30 and the Virginia legislative code site at Virginia Law.

QUESTION NO: 25

(Under which type of retirement plan does the employer contribute to an individual retirement account (IRA) established by the employee?)

A. HR-10 plan

B. 403(b) plan

C. Simplified employee pension plan (SEP)

D. Savings incentive match plan for employees (SIMPLE)

ANSWER: C

Explanation:

A Simplified employee pension plan (SEP) is the retirement arrangement designed around employer contributions to individual retirement accounts established for eligible employees. Under a SEP, an employer establishes the plan and makes contributions directly to each participating employee’s SEP-IRA. The contributions are employer-funded rather than employee salary deferrals, although an employee may separately make regular IRA contributions if otherwise eligible. SEP contributions generally must be made at the same percentage of compensation for each eligible employee, subject to applicable annual contribution limits, and amounts contributed to an employee’s SEP-IRA are immediately fully vested. This structure lets smaller employers offer a tax-favored retirement benefit without administering a traditional qualified pension trust or maintaining individual participant accounts within an employer-sponsored plan. The IRS describes a SEP as a plan under which an employer contributes to traditional IRAs set up for employees, directly matching the retirement-plan structure asked about here. See the IRS’s SEP plan FAQs and its overview of Simplified Employee Pension plans.

QUESTION NO: 26

If all beneficiaries die before the insured dies, the proceeds of a life insurance policy will be paid to:

A. The insured ' s creditors

B. A beneficiary named by the court

C. The insured ' s estate

D. The beneficiary ' s estate

ANSWER: C

Explanation:

The insured ' s estate is correct. A life insurance policy pays its death benefit according to the beneficiary designation in force when the insured dies. If every named beneficiary—including any contingent or secondary beneficiary—has died before the insured, there is no living person or entity eligible to receive the proceeds under that designation. The policy proceeds then become payable to the insured’s estate, subject to the policy’s terms. The personal representative of the estate receives and administers the money as an estate asset, after which it is distributed under the insured’s valid will or, if

there is no will, under Virginia's laws of intestate succession. This result reflects the basic principle that a beneficiary must survive the insured to take policy proceeds. Virginia's simultaneous-death law similarly directs that, when applicable, life-insurance proceeds are distributed as though the insured survived a beneficiary who is not established to have survived the insured. That rule supports payment through the insured's estate when no beneficiary survives. See Virginia Code § 64.2-2208, available from the Virginia Legislative Information System, and the Virginia State Corporation Commission's Bureau of Insurance resources.

QUESTION NO: 27

The employer who receives and holds the insurance policy is known as the:

A. Group director

B. Benefit coordinator

C. Master policyholder

D. Policy beneficiary

ANSWER: C

Explanation:

The employer who receives and holds a group insurance contract is the **Master policyholder**. In a group life insurance arrangement, the insurer issues one master policy to the employer or other eligible sponsoring entity, such as an association or trust. This entity is the contractual policyholder and administers certain plan functions, including providing enrollment information and premium-related information to the insurer. Covered employees generally do not receive separate individual policies. Instead, they receive certificates of insurance describing their coverage, benefits, eligibility conditions, and rights under the group contract. This structure allows the insurer to insure a defined group under a single contract while documenting each insured employee's coverage through a certificate. Virginia insurance law specifically addresses group life policies issued to an employer or other qualifying policyholder and requires insurers to furnish certificates to insured persons. See the Virginia Legislative Information System's group life insurance provisions at Virginia Code, Title 38.2, Chapter 35. For additional background on how group life insurance operates, including the issuance of certificates to employees under a group policy, see the Insurance Information Institute's group life insurance overview.

QUESTION NO: 28

Which type of life insurance policy is designed to pay the balance of a thirty-year home mortgage loan in the event of the insuredâ€™s death?

A. 30-payment whole life

B. 30-year decreasing term

C. 30-year level term

D. 30-year endowment

ANSWER: B

Explanation:

30-year decreasing term is designed for a debt that declines over a defined period, such as a fully amortized 30-year home mortgage. Under this type of term insurance, the policy's face amount decreases according to a stated schedule during its 30-year term. That declining death benefit is intended to correspond generally with the falling unpaid principal balance of the mortgage. If the insured dies while the mortgage remains outstanding, the policy proceeds can be used to satisfy or substantially pay off the remaining loan balance, helping protect surviving family members from the mortgage obligation.

This coverage is commonly called mortgage protection insurance when it is structured for that purpose. The term period should align with the mortgage repayment period, and the initial amount of insurance should be selected with the loan

balance in mind. Because the insurance amount decreases as the underlying debt is paid down, decreasing term insurance can provide coverage tailored to the changing financial exposure rather than maintaining the same death benefit throughout the entire period. Virginia recognizes and regulates term life insurance under its life-insurance provisions; see Virginia Code § 38.2-3301. For consumer-oriented discussion of term life insurance and matching coverage to financial needs, see the NAIC Life Insurance Buyer's Guide.

QUESTION NO: 29

If an agent unknowingly violates insurance laws, what is the maximum aggregate penalty for similar violations occurring?

A. $5,000

B. $7,500

C. $10,000

D. $15,000

ANSWER: C

Explanation:

$10,000 is the maximum aggregate civil penalty for violations of a similar nature when the agent did not knowingly violate Virginia insurance law. Virginia Code § 38.2-218 authorizes the State Corporation Commission to impose a civil penalty for violations of Title 38.2 and establishes a separate aggregate cap for similar violations. For an unknowing violation, the per-violation penalty may not exceed $1,000, and the total penalty for all violations of a similar nature may not exceed $10,000. The rule distinguishes an inadvertent or unknowing failure to comply from conduct performed with knowledge of the violation; the question specifically uses "unknowingly," so the unknowing-violation aggregate limit applies. This provision is part of the Commission's authority to enforce Virginia insurance statutes and may be applied to licensed agents and other persons subject to the insurance title. See Virginia Code § 38.2-218. The Virginia Bureau of Insurance, within the State Corporation Commission, administers and enforces insurance licensing and regulatory requirements; its official regulatory information is available at Virginia SCC Bureau of Insurance.

QUESTION NO: 30

A disability income insurance policy typically provides coverage for disabilities resulting from:

A. Accidents only

B. Sickness only

C. Both accidents and sickness

D. Occupational accidents only

ANSWER: C

Explanation:

Both accidents and sickness is correct because disability income insurance is intended to replace a portion of an insured person's earnings when a covered disability prevents that person from working. In standard individual disability-income coverage, the covered cause of disability generally includes both accidental bodily injury and sickness, subject to the policy's definitions, waiting period, benefit period, exclusions, and any optional riders. The benefit is tied to loss of earning capacity or income caused by the disability; it is not limited to a particular type of medical cause merely because the disability began with an accident or an illness.

This broad accident-and-sickness framework is consistent with Virginia insurance law's treatment of accident and sickness insurance. Virginia defines accident and sickness insurance as insurance against bodily injury, disablement, or death by accident, and against disablement resulting from sickness. See Virginia Code § 38.2-109. For examination purposes, disability income coverage should therefore be understood as protection for income loss due to either a covered accident or

a covered sickness. Actual policy language remains important because it establishes the applicable definitions and exclusions. Virginia's insurance statutes are available through the Virginia Legislative Information System.

QUESTION NO: 31

When a health insurance policy provision is in conflict with the statutes of Virginia, it is:

A. Declared void and removed from the policy

B. Used as is until the policy renewal date

C. Amended to conform to the minimum statutory requirements

D. Amended to conform to the maximum statutory requirements

ANSWER: C

Explanation:

"Amended to conform to the minimum statutory requirements" is correct because Virginia health insurance policies must contain a conformity-with-state-statutes provision. That provision operates automatically when a policy term conflicts with the law of the state in which the insured resides on the policy's effective date. Rather than allowing a conflicting term to control, the policy is treated as amended so that it meets the minimum protections and requirements imposed by the applicable statute. This rule preserves the policy's overall operation while ensuring that an insured receives the baseline coverage rights, safeguards, and contractual standards required under Virginia law. It also prevents an insurer from relying on policy language that provides less than what the governing statutes require. The focus on minimum requirements is important: the statute supplies the legal floor to which the policy must conform, not a maximum level of benefits or obligations. Virginia's required health insurance policy provisions are set out in the Code of Virginia, including the conformity-with-state-statutes requirement. See Va. Code § 38.2-3503 and the Virginia Legislative Information System's Chapter 35 health insurance policy provisions.

QUESTION NO: 32

(Under a group life insurance policy delivered in Virginia in which the employer is deemed to be the policyholder, which of the following is included in the term "employee" under the policy?)

A. Credit union

B. Individual proprietor

C. Labor union

D. Trade association

ANSWER: B

Explanation:

Individual proprietor is included within the statutory meaning of "employee" for this type of Virginia group life insurance arrangement. Virginia's group life insurance law permits an employer to be the policyholder for insurance covering its employees and defines that employee group broadly enough to include business owners in appropriate business structures. In particular, an individual proprietor may be treated as an employee for purposes of coverage under an employer group policy. This treatment recognizes that a sole proprietor can actively perform services in, and be economically dependent on, the business even though that person is also its owner. Accordingly, the policy's employee class is not limited solely to conventional wage-earning personnel when the policyholder is an employer. The governing group-life provisions are found in the Virginia Insurance Code, which establishes the permitted groups and the employee categories that may be insured. See the Virginia Code, Title 38.2, Chapter 33 and the Virginia Legislative Information System's official Virginia Code database.

QUESTION NO: 33

The insurance with other insurers provision in an individual health insurance policy allows an insurer to pay benefits to the insureds on a pro-rata basis when the:

A. Policy is within 31 days of the renewal date

B. Policy has entered into the grace period for premium payment

C. Insurer was not notified prior to the claim that the insured has other health coverage

D. Insured has submitted claims in excess of $2,000 during the policy year

ANSWER: C

Explanation:

“Insurer was not notified prior to the claim that the insured has other health coverage” is correct. Virginia permits an individual accident and sickness policy to contain an insurance-with-other-insurers provision. Under that provision, when the insured has other valid coverage for the same loss and the insurer was not given written notice of that other coverage before the loss, the insurer’s liability may be limited to its proportionate share of the covered loss. In practical terms, the insurer determines its share by comparing the amount of insurance provided under its policy with the total amount of insurance covering the loss. This prevents duplicate recovery beyond the actual covered expense while allocating payment fairly among applicable policies. The policy provision also requires the insurer to return any premium paid for the excess insurance amount when the provision is applied, subject to the statutory conditions. This rule concerns notice of other insurance and the existence of overlapping coverage; it is not dependent on a renewal date, premium grace period, or a particular dollar amount of claims. The governing Virginia individual accident and sickness policy provision is found in Virginia Code § 38.2-3514. Additional statutory context for required and optional policy provisions is available through the Virginia Code, Chapter 35.

QUESTION NO: 34

(A single premium whole life insurance policy may be defined as a policy that provides:)

A. Protection for only a limited number of years

B. A decreasing amount of insurance over its duration

C. Protection for life as a paid-up policy

D. A life annuity benefit in addition to insurance

ANSWER: C

Explanation:

Protection for life as a paid-up policy is correct because single-premium whole life insurance is permanent life insurance funded by one lump-sum premium paid when the policy is issued. That single payment is designed to fully fund the policy, so the policyowner has no scheduled future premium obligation. The insurance remains in force for the insured’s lifetime, provided the contract is not surrendered and any policy loans do not cause it to lapse. Like other whole life policies, it generally includes a guaranteed death benefit and builds cash value under the terms of the contract. “Paid-up” describes the fact that all required premiums have already been paid, not that the death benefit has been paid. This policy design contrasts with coverage that expires after a stated period; its defining feature is lifelong protection financed at inception by one premium. Virginia insurance law recognizes life insurance as insurance on human lives, including benefits payable upon death, and Virginia’s consumer materials distinguish permanent life insurance from temporary term coverage. See the Virginia definition of life insurance and the NAIC life insurance consumer overview.

QUESTION NO: 35

The period of time during which a new employee is ineligible for group health insurance coverage is called a:

A. Participation period

B. Grace period

C. Probationary period

D. Contributory period

ANSWER: C

Explanation:

Probationary period is the correct term for the initial period after an employee begins work during which the employee is not yet eligible to enroll in the employer's group health insurance plan. In group-insurance terminology, this is commonly also described as a waiting period. The employer's plan establishes the eligibility conditions and the point at which coverage becomes available, subject to applicable state and federal requirements. The important concept is that the employee is in an initial employment-status period before group health coverage eligibility begins.

Federal health-insurance rules define a waiting period as the time that must pass before coverage becomes effective for an individual otherwise eligible to enroll, and they generally prohibit waiting periods longer than 90 days. Thus, "probationary period" accurately identifies the employee's pre-eligibility interval in the context tested by this question. See the federal waiting-period rule at 45 C.F.R. § 147.116 and Virginia's group accident and sickness insurance provisions at Virginia Code, Chapter 34.

QUESTION NO: 36

Group term insurance coverage can usually be converted to:

A. Another group term policy

B. A yearly renewable term policy

C. A permanent individual life insurance policy

D. A decreasing term policy

ANSWER: C

Explanation:

Group term life insurance ordinarily includes a conversion privilege that allows a covered employee or member to obtain an individual permanent life insurance policy when group coverage terminates or the person ceases to be eligible for the group. The conversion is generally available without evidence of insurability, so the person does not have to undergo a medical examination or prove acceptable health. This protection is particularly important for an insured whose health has changed since first becoming covered under the employer or association plan.

The individual policy issued under the conversion privilege is typically a form of permanent insurance offered by the insurer, commonly whole life insurance, rather than a continuation of the group contract. Although the premium for the individual permanent policy is generally higher because the group subsidy and group risk pooling no longer apply, the conversion right preserves the insured's ability to maintain life insurance coverage. Virginia's group life insurance statutes require group policies to provide a conversion privilege to an individual policy of life insurance when group coverage ends, subject to the policy's conditions and conversion period. See Virginia Code § 38.2-3542 and the NAIC Life Insurance Buyer's Guide.

QUESTION NO: 37

An agentâ€™s appointment with an insurer:

A. Is in effect until terminated

B. Must be renewed quarterly

C. Must always be approved by the NAIC

D. Can only be terminated after a proper hearing

ANSWER: A

Explanation:

Is in effect until terminated is correct. Under Virginia insurance producer licensing law, an insurer's appointment of an agent is continuing rather than being issued for a fixed quarterly term. Once the insurer files the appointment as required and it becomes effective, it remains in force unless and until it is terminated. This continuing status permits the properly appointed agent to represent the insurer for the authorized lines of insurance without having to obtain a periodic appointment renewal merely because time has passed.

Virginia law places responsibility on the appointing insurer to notify the Virginia Bureau of Insurance when an appointment is terminated. The Bureau also has authority under the insurance laws to act on appointments and producer licensing matters. Thus, the key exam rule is that the appointment continues until termination, rather than expiring on a recurring schedule. The governing appointment statute is Virginia Code § 38.2-1833. Related Virginia producer appointment procedures are published by the Virginia State Corporation Commission Bureau of Insurance.

QUESTION NO: 38

EXCEPT for fraud, what is the time limit after issue for an insurer to deny an individual health insurance claim based on material misrepresentation in the application?

A. 180 days

B. 1 year

C. 2 years

D. 3 years

ANSWER: C

Explanation:

2 years is correct because Virginia's required individual accident and sickness insurance policy provisions include a time-limit-on-certain-defenses rule, commonly called an incontestability provision. Once the policy has been in force for two years from its date of issue, an insurer generally may not use a misstatement in the application to void the policy or deny a claim for a loss that begins after that two-year period. The stated exception is fraudulent misstatements, which remain subject to challenge. This rule gives an insured meaningful long-term certainty that coverage will not later be withdrawn because of an application misrepresentation after the statutory contestability period has expired, while preserving the insurer's ability to address actual fraud. The two-year period is measured from the policy's date of issue, not from the date a claim is filed or the date a disability or illness is discovered. Virginia codifies the required provision for individual accident and sickness policies in Virginia Code § 38.2-3503. The Virginia Bureau of Insurance also regulates accident and sickness insurance under Title 38.2; see the Virginia State Corporation Commission Bureau of Insurance.

QUESTION NO: 39

Since HMOs negotiate provider networks in advance of care, HMO members:

A. Pay the entire cost for all use of non-HMO providers, regardless of circumstances

B. Have a limited choice of care providers

C. Waive the right to re-enroll in an insurance company indemnity plan

D. Are encouraged to carry individual health insurance coverage

ANSWER: B

Explanation:

Have a limited choice of care providers is correct because an HMO (health maintenance organization) delivers covered care through a defined service area and a contracted network of physicians, hospitals, and other providers. The HMO arranges and negotiates with these providers before a member receives treatment, commonly establishing payment terms and care-management requirements in advance. In exchange for this organized, managed-care structure, members generally select or are assigned a primary care provider and receive the plan's highest level of coverage when they use participating network providers. This network-based arrangement is central to the HMO model: it enables coordinated care and helps the organization control and predict medical costs. Members therefore do not have the unrestricted provider choice associated with traditional indemnity coverage. The exact rules for referrals, network access, and coverage of emergency services can vary by plan and must comply with applicable law, but the defining general characteristic tested here is limited access to a prearranged panel of providers. The Virginia Bureau of Insurance regulates health maintenance organizations under Virginia insurance law; see Virginia Code, Chapter 43: Health Maintenance Organizations. For a consumer overview of how HMO provider networks operate, see HealthCare.gov: Health insurance plan types.

QUESTION NO: 40

All of the following statements about straight whole life insurance policies are true EXCEPT:

A. Protection ends at the insured's age 65

B. Premiums are payable for as long as the policy remains in force

C. Loan and nonforfeiture values are available to the policyowner

D. The face amount is paid when the insured survives to policy maturity

ANSWER: A

Explanation:

Protection ends at the insured's age 65 is the exception because straight whole life is a form of permanent life insurance, not coverage designed to expire at a specified working-age milestone. Its defining structure is level premiums that are generally payable for the insured's lifetime, together with lifetime death-benefit protection while the policy remains in force. If the insured reaches the policy's maturity age, the policy provides for payment of its face amount under the policy's maturity provision. Maturity ages are set by the contract and applicable requirements; modern policies commonly use a maturity age later than age 65. Virginia's statutory framework for individual life insurance recognizes policies with cash values and nonforfeiture benefits and includes standards addressing maturity, underscoring that whole life is intended as long-duration permanent coverage rather than age-65 coverage. See the Virginia individual life insurance provisions at Virginia Code, Title 38.2, Chapter 31, including the nonforfeiture standards in § 38.2-3100. Therefore, an assertion that straight whole life protection ends at age 65 does not describe this policy type.

QUESTION NO: 41

All changes and corrections made to an application for health insurance by an agent must be initialed by the:

A. Agent

B. Applicant

C. Applicantâ€™s physician

D. Insurance company underwriter

ANSWER: B

Explanation:

Applicant is correct because the applicant's initials document that the applicant has reviewed and approved each alteration made by the agent before the application is submitted. An insurance application gathers material information used by the insurer to evaluate eligibility, premium rating, and coverage terms. Requiring the applicant to initial corrections helps preserve an accurate record of what the applicant represented and confirms that an alteration was not made without the applicant's knowledge or consent.

This requirement also supports the contractual significance of the application. Under Virginia's individual accident and sickness insurance requirements, the application may become part of the insurance contract when attached to or endorsed on the policy. The applicant's initials next to a correction provide evidence that the final information was accepted by the person making the representations. This consumer-protection practice is especially important when a correction affects information such as age, medical history, address, or other underwriting details. Virginia insurance law's provisions concerning policy applications and the entire-contract framework are available through the Virginia Legislative Information System, § 38.2-3501. The Virginia Bureau of Insurance also provides regulatory and consumer insurance resources at the Virginia State Corporation Commission Bureau of Insurance.

QUESTION NO: 42

(What is the maximum percentage of total employee payroll that an employer may contribute to a profit-sharing plan?)

A. 25%

B. 28%

C. 30%

D. 33%

ANSWER: A

Explanation:

25% is the maximum percentage commonly tested for employer contributions to a qualified profit-sharing plan. Under federal qualified-plan tax rules, the employer's deductible contribution limit for a profit-sharing plan is generally based on 25% of the compensation paid or accrued during the year to eligible employees participating in the plan. This payroll-based limitation is a key feature of defined-contribution retirement arrangements, including profit-sharing plans. The amount an employer elects to contribute may vary from year to year, including an election to make no contribution for a particular year when the plan terms permit it. When a contribution is made, however, the plan must be operated within applicable qualification, deduction, and allocation requirements to retain its favorable tax treatment. For licensing-exam purposes, the relevant maximum is therefore 25% of eligible employee payroll/compensation. The IRS explains the deduction rules for employer contributions to qualified retirement plans in Retirement Plan Contribution Deduction Limits. Additional IRS guidance describing profit-sharing plans is available in Profit-Sharing Plans for Small Businesses.

QUESTION NO: 43

The injury or damage sustained by the insured is called:

A. A claim

B. A peril

C. A loss

D. An accident

ANSWER: C

Explanation:

The injury or damage sustained by the insured is a **loss**. In insurance terminology, a loss is the reduction in value, bodily injury, property damage, or other financial detriment that results when a covered event occurs. For example, damage to a

home caused by fire, the cost of repairing a vehicle after a collision, or medical expenses arising from an injury may each constitute a loss. The insurance policy identifies the types of losses for which coverage may be available, along with the applicable conditions, exclusions, limits, and deductibles. Once a loss occurs, the insured generally provides notice to the insurer and may submit information supporting the amount and circumstances of the loss. This terminology is fundamental across life, health, property, casualty, and liability insurance, although the form of the loss differs by line of insurance. The National Association of Insurance Commissioners’ consumer glossary defines “loss” as the amount an insurer pays because of a covered event, while insurance education materials also use the term for the injury or damage itself. See the NAIC insurance terms glossary and the Insurance Information Institute overview of insurance.