

ARIZONA LIFE AND HEALTH PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which statement is true about a decreasing term life policy?**
 - A. The face amount increases over the policy period
 - B. The face amount is fixed and does not change
 - C. The face amount decreases over the policy period
 - D. The policy provides a cash value component
- 2. When a ten year renewable term life insurance policy is renewed at age 55, what will be the basis for the premium rate?**
 - A. Current rate for a 45-year-old
 - B. Current rate for a 50-year-old
 - C. Current rate for a 55-year-old
 - D. Current rate for a 65-year-old
- 3. Under what provision can a policy be canceled for non-payment after a grace period?**
 - A. Cancellation Clause
 - B. Termination Clause
 - C. Grace Period Clause
 - D. Retention Clause
- 4. After an applicant reads and signs an insurance application, he/she should be conscious of the fact that?**
 - A. A false statement could lead to loss of coverage
 - B. The application can be changed at any time
 - C. The policy will be issued automatically
 - D. Signature is not required for processing
- 5. What is the actuarial value of a bronze level health plan under the Affordable Care Act?**
 - A. 70%
 - B. 80%
 - C. 60%
 - D. 50%

- 6. What is the purpose of a "notice of information practices" in health insurance?**
- A. To inform clients about premium rates.
 - B. To explain the use of their personal health information.
 - C. To offer advice on selecting a policy.
 - D. To outline the claims process.
- 7. The purpose of the 'No-loss No-gain' provision is to avoid duplication of what?**
- A. Insurance policies and benefits
 - B. Premiums and deductibles
 - C. Benefit payments and overinsurance
 - D. Claims and reimbursements
- 8. When must the notice of application practices be provided to the applicant?**
- A. Within 30 days of application submission
 - B. At least one week before the application is submitted
 - C. No later than the application date
 - D. On the policy delivery date
- 9. What is the term for the period during which an insurer can delay a covered disability policy claim?**
- A. Waiting period
 - B. Grace period
 - C. Elimination period
 - D. Coverage period
- 10. Which type of insurance plan typically offers lower premiums for associated healthcare services?**
- A. Indemnity Plan
 - B. Exclusive Provider Organization (EPO)
 - C. Health Maintenance Organization (HMO)
 - D. Medicare Supplement Plan

Answers

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1. C
2. C
3. B
4. A
5. C
6. B
7. C
8. C
9. C
10. C

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Explanations

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1. Which statement is true about a decreasing term life policy?

- A. The face amount increases over the policy period
- B. The face amount is fixed and does not change
- C. The face amount decreases over the policy period**
- D. The policy provides a cash value component

A decreasing term life policy is specifically designed such that the face amount, or the death benefit, decreases over the policy's duration. This feature makes it distinct from other types of life insurance policies. Typically, a decreasing term policy is structured to align with specific financial obligations that diminish over time, such as a mortgage or a loan. As these obligations reduce, the death benefit reflects this decrease, providing a range of benefits that correspond with the insured's changing financial responsibilities. In contrast, the other statements do not accurately describe the nature of a decreasing term life policy. The face amount does not increase over time, nor is it fixed without change; it specifically decreases. Additionally, a decreasing term life policy does not have a cash value component, as it is pure insurance protection for a specified term without any savings or investment feature. Thus, the defining characteristic of a decreasing term policy is the reduction of the face amount as the policy period progresses.

2. When a ten year renewable term life insurance policy is renewed at age 55, what will be the basis for the premium rate?

- A. Current rate for a 45-year-old
- B. Current rate for a 50-year-old
- C. Current rate for a 55-year-old**
- D. Current rate for a 65-year-old

The premium rate for a renewed ten-year renewable term life insurance policy is based on the insured's current age at the time of renewal. When the policy is renewed at age 55, the insurance company will calculate the premium using the rates applicable to a 55-year-old. This is due to the nature of renewable term insurance, which allows the policyholder to renew their coverage without the need for additional medical underwriting but considers the insured's age for premium determination. As individuals age, the risk associated with insuring them generally increases, leading to higher premiums. Therefore, it is standard practice for insurers to adjust premiums according to the insured's age at the point of renewal rather than the original age or some other arbitrary age. This reflects the increasing likelihood of claims as one gets older, ensuring that the insurance company can adequately cover potential future liabilities.

3. Under what provision can a policy be canceled for non-payment after a grace period?

- A. Cancellation Clause
- B. Termination Clause**
- C. Grace Period Clause
- D. Retention Clause

The correct provision that allows a policy to be canceled for non-payment after a grace period is referred to as the Termination Clause. This clause outlines the conditions under which a policy can be terminated, including the stipulation that if premiums are not paid within the grace period, the insurer has the right to cancel the policy. The Termination Clause serves as a safeguard for insurers, ensuring that policies that are no longer financially supported by the policyholder can be ended to avoid further losses. The grace period allows policyholders time to make their payments without immediate penalty, which balances the insurer's need for timely premium collection with the policyholder's opportunity to rectify missed payments. In contrast, while the Cancellation Clause generally deals with the rights and responsibilities concerning cancellation, and the Grace Period Clause specifically pertains to the time allowed for premium payment, it is the Termination Clause that explicitly encompasses the cancellation for non-payment after the consideration of the grace period. The Retention Clause, on the other hand, typically pertains to the retention of risk by an insurer rather than the cancellation process.

4. After an applicant reads and signs an insurance application, he/she should be conscious of the fact that?

- A. A false statement could lead to loss of coverage**
- B. The application can be changed at any time
- C. The policy will be issued automatically
- D. Signature is not required for processing

The correct answer highlights a critical aspect of insurance applications: a false statement can indeed lead to a loss of coverage. This stems from the principle of "material misrepresentation," which means that if an applicant provides information that is intentionally misleading or inaccurate, it may affect the insurer's decision to issue a policy or the terms on which the policy is provided. When signing an insurance application, the applicant is affirmatively stating that the information provided is true and complete to the best of their knowledge. If it is later discovered that the applicant withheld material information or provided false statements, the insurance company may have grounds to deny a claim or even void the policy altogether. Therefore, applicants must be diligent in providing honest and accurate information. In contrast, other statements in the choices listed do not accurately reflect the nature of the insurance application process. The notion that an application can be altered at any time is misleading, as changes typically require additional documentation or approvals. The idea that a policy will be issued automatically disregards the underwriting process where the insurer assesses the risk based on the application details before making a final decision. Lastly, stating that a signature is not required for processing is incorrect, as the signature is a necessary part of affirming that the applicant agrees to the terms and

5. What is the actuarial value of a bronze level health plan under the Affordable Care Act?

- A. 70%
- B. 80%
- C. 60%**
- D. 50%

The actuarial value of a bronze-level health plan under the Affordable Care Act is 60%. This means that, on average, a bronze plan is designed to cover 60% of the total costs of healthcare services for a typical population, with the remaining 40% of costs being the responsibility of the insured individuals through out-of-pocket expenses, such as deductibles, copayments, and coinsurance. The tiered system established by the Affordable Care Act includes four levels of coverage: bronze, silver, gold, and platinum, each differentiated by its actuarial value. Bronze has the lowest level of coverage among these tiers, which impacts both the premiums and cost-sharing for enrollees. The structure incentivizes consumers to choose plans that align with their healthcare usage and financial needs. Understanding the actuarial value is crucial for consumers, as it informs them about what to expect in terms of out-of-pocket costs versus premiums, aiding in making informed decisions when selecting a health plan.

6. What is the purpose of a "notice of information practices" in health insurance?

- A. To inform clients about premium rates.
- B. To explain the use of their personal health information.**
- C. To offer advice on selecting a policy.
- D. To outline the claims process.

The purpose of a "notice of information practices" in health insurance is to explain how personal health information will be used and protected by the insurance company. This notice is a crucial part of transparency in the health insurance process, as it informs policyholders about their rights regarding their medical information, including how their data may be shared with third parties and under what conditions. By providing this information, the notice helps to ensure that individuals understand their privacy rights and can make informed decisions regarding their healthcare. It also reflects the compliance requirements set by laws such as the Health Insurance Portability and Accountability Act (HIPAA), which aim to safeguard individual health information. This focus on the handling of personal information distinguishes this notice from other options. For instance, informing clients about premium rates does not relate to privacy practices, advice on selecting a policy pertains more to coverage options than to information use, and outlining the claims process addresses the procedural aspects of insurance, rather than the protection and use of private health data.

7. The purpose of the 'No-loss No-gain' provision is to avoid duplication of what?

- A. Insurance policies and benefits
- B. Premiums and deductibles
- C. Benefit payments and overinsurance**
- D. Claims and reimbursements

The 'No-loss No-gain' provision is primarily designed to prevent overinsurance and ensure that an insured individual does not receive more in benefits than what they have lost. This provision is intended to maintain the principle of indemnity in insurance, where the goal is to restore the insured to the financial position they were in before the loss, rather than allowing them to profit from it. By implementing this provision, insurers can avoid situations where a policyholder might receive multiple benefit payments from different policies for the same loss, leading to a financial gain above their actual loss. This ensures that the benefits paid out align more closely with the actual financial impact experienced by the policyholder and prevents the potential for fraudulent claims or excessive insurance coverage. In contrast to this, other options relate to aspects such as premiums, deductibles, and reimbursements, which, while related to overall insurance practices, do not specifically address the primary concern of preventing a situation where the insured receives benefits that exceed their losses.

8. When must the notice of application practices be provided to the applicant?

- A. Within 30 days of application submission
- B. At least one week before the application is submitted
- C. No later than the application date**
- D. On the policy delivery date

The correct answer is that the notice of application practices must be provided no later than the application date. This requirement ensures that the applicant is fully informed about the practices related to their application when they are submitting it. Providing this notice at this time allows the applicant to understand how their information may be used and what to expect during the application process. This aligns with regulatory standards intended to promote transparency and protect consumer rights. By ensuring that applicants receive this important information at the time of application submission, it helps them make informed decisions about their insurance needs. In contrast, the other options suggest timelines that do not align with the requirement for transparency at the point of application. For instance, providing the notice after the application date would not allow applicants the opportunity to consider the practices beforehand. Similarly, offering the notice one week in advance or during policy delivery does not fulfill the regulatory intent of ensuring the applicant is informed at the critical point of submitting their application.

9. What is the term for the period during which an insurer can delay a covered disability policy claim?

- A. Waiting period
- B. Grace period
- C. Elimination period**
- D. Coverage period

The term for the period during which an insurer can delay a covered disability policy claim is known as the elimination period. This is a specific timeframe following the onset of a disability during which the policyholder will not receive any benefits. The elimination period can vary by policy but is essential in determining when the insurance coverage will begin to pay benefits. This period serves multiple purposes, including allowing insurers to limit exposure to claims that might arise from short-term disabilities and encouraging policyholders to return to work quickly. It is important for insured individuals to be aware of the length of this elimination period when planning for potential health issues, so they understand the timeline for when they can expect to receive benefits after an incident occurs. Understanding the elimination period is crucial for effective financial planning in the event of a disability.

10. Which type of insurance plan typically offers lower premiums for associated healthcare services?

- A. Indemnity Plan
- B. Exclusive Provider Organization (EPO)
- C. Health Maintenance Organization (HMO)**
- D. Medicare Supplement Plan

A Health Maintenance Organization (HMO) plan is known for offering lower premiums for associated healthcare services, primarily because it emphasizes preventive care and requires members to choose a primary care physician (PCP). This structure allows for better management of patient care and reduces overall costs for the insurer. HMOs typically cover services only when provided by in-network doctors and facilities, which helps control healthcare expenses and results in lower premium rates compared to other types of plans. In contrast, indemnity plans generally allow for greater flexibility in choosing healthcare providers, leading to higher costs as members can seek services from any healthcare entity, which tends to drive up premiums. Exclusive Provider Organizations (EPOs) share some characteristics with HMOs but usually offer less restrictive provider networks, which can result in higher costs. Medicare Supplement Plans, designed to cover gaps in Medicare coverage, are also generally not associated with lower premiums as they provide additional benefits that come with higher costs for those enrollees. Therefore, the structure and cost-management strategies of HMOs make them the choice for lower premium rates among healthcare insurance options.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://arizonalifeandhealth.examzify.com>

We wish you the very best on your exam journey. You've got this!

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