

# CUNA Insurance Producer Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

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**SAMPLE**

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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

- 1. What must occur following a written notification from the commissioner regarding suspension or revocation?**
  - A. A hearing must be held within 10 days**
  - B. A hearing must be held within 30 days**
  - C. A hearing must be held within 15 days**
  - D. A hearing must be held within 45 days**
- 2. What is the purpose of a license or charter for an insurer?**
  - A. To establish premium rates**
  - B. To authorize an insurer to conduct business**
  - C. To limit the types of insurance sold**
  - D. To recruit new agents**
- 3. What does the term "insurance rating" fundamentally involve?**
  - A. Setting customer service standards**
  - B. Calculating how much coverage is needed**
  - C. Determining premiums based on risk assessment**
  - D. Evaluating the effectiveness of marketing campaigns**
- 4. What principle ensures that both the insurer and the insured cannot attempt to conceal or deceive each other?**
  - A. Utmost good faith**
  - B. Consideration**
  - C. Reciprocal obligation**
  - D. Transparency**
- 5. Who can be classified as an agent in the insurance process?**
  - A. A customer purchasing insurance**
  - B. A licensed person collecting claims**
  - C. A person soliciting sales of insurance products**
  - D. An underwriter evaluating risks**

- 6. The act of providing false information to an insurer for personal gain is known as what?**
- A. Negligence**
  - B. Insurance fraud**
  - C. Moral hazard**
  - D. Risk management**
- 7. What is the time frame for an insured to notify an insurer of a claim after a loss?**
- A. 10 days**
  - B. 20 days**
  - C. 30 days**
  - D. The policy year**
- 8. Which term refers to the competition among insurers to retain business?**
- A. Coercion**
  - B. Competitive Advantage**
  - C. Boycott**
  - D. Market Competition**
- 9. Who is normally offered credit accident and health insurance?**
- A. Any borrower**
  - B. Only individuals under 30 years of age**
  - C. The primary borrower actively at work**
  - D. Secondary borrowers**
- 10. What might NOT be a reason for a claim denial in insurance?**
- A. Policy exclusions**
  - B. Failure to pay premiums**
  - C. Excess claims by the insured**
  - D. Inadequate coverage levels**



## **Answers**

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

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## **Explanations**

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**1. What must occur following a written notification from the commissioner regarding suspension or revocation?**

- A. A hearing must be held within 10 days**
- B. A hearing must be held within 30 days**
- C. A hearing must be held within 15 days**
- D. A hearing must be held within 45 days**

When the commissioner issues a written notification concerning the suspension or revocation of a license, it is mandated that a hearing must take place within a specified timeframe. Holding a hearing within 15 days of the written notification ensures that the licensee's right to a prompt review of the commissioner's action is protected. This timeframe allows for an expedited process so that the licensee can respond to the accusations or concerns raised by the commissioner and present their case. This 15-day requirement is in place to provide a balance between the need for regulatory enforcement and the rights of individuals or entities to contest administrative decisions in a timely manner. Delays in these processes could hinder the ability of the licensee to maintain their business operations, hence the necessity for a prompt hearing.

**2. What is the purpose of a license or charter for an insurer?**

- A. To establish premium rates**
- B. To authorize an insurer to conduct business**
- C. To limit the types of insurance sold**
- D. To recruit new agents**

The purpose of a license or charter for an insurer is to authorize an insurer to conduct business. This authorization serves as a regulatory measure that ensures the insurer meets specific criteria set by state insurance departments, thereby protecting consumers. By obtaining a license or charter, an insurer demonstrates compliance with legal requirements and financial stability, which enables it to operate within a given jurisdiction. This regulatory oversight helps maintain the integrity of the insurance market and builds trust among policyholders, knowing that the insurer is recognized by regulatory authorities to conduct insurance business. In this context, the other options do not directly reflect the primary function of a license or charter. For example, while establishing premium rates might be a necessary part of an insurer's operations, it is not the primary purpose of the license itself.

**3. What does the term "insurance rating" fundamentally involve?**

- A. Setting customer service standards**
- B. Calculating how much coverage is needed**
- C. Determining premiums based on risk assessment**
- D. Evaluating the effectiveness of marketing campaigns**

The term "insurance rating" fundamentally involves determining premiums based on risk assessment. This process is crucial for insurance companies as it allows them to evaluate the likelihood of a claim being made based on the information provided about the insured risk, such as age, health, property condition, and other relevant factors. The assessment leads to the establishment of appropriate premium rates that reflect the level of risk associated with covering the insured party. By accurately assessing risks, insurers can set premiums that are statistically calculated to ensure that they remain profitable while also being fair to customers. This is essential for maintaining financial stability within the insurance market and ensuring that funds are available to cover claims. In contrast, setting customer service standards, calculating the necessary coverage, and evaluating marketing effectiveness do not directly relate to the core function of insurance rating, which is specifically focused on pricing insurance based on risk. Therefore, understanding this concept is key for anyone working in the insurance field, as it impacts both the insurer's success and the customer's premiums.

**4. What principle ensures that both the insurer and the insured cannot attempt to conceal or deceive each other?**

- A. Utmost good faith**
- B. Consideration**
- C. Reciprocal obligation**
- D. Transparency**

The principle that ensures both the insurer and the insured cannot conceal or deceive each other is known as utmost good faith. This fundamental concept, also referred to as "uberrima fides," requires both parties to act honestly and disclose all relevant information during the formation of an insurance contract. In an insurance context, this means that the insured must provide truthful information about their risk profile, while the insurer must disclose the terms, limitations, and conditions of the insurance policy. This mutual obligation is critical because it helps to prevent fraud and misunderstandings, thereby fostering trust between the parties involved. When both sides adhere to the principle of utmost good faith, it promotes fair dealings and helps ensure that coverage is appropriate and claims are processed fairly. The other options, while related to various aspects of insurance contracts, do not encapsulate this essential duty of honesty and full disclosure. Consideration refers to something of value that is exchanged between the parties, reciprocal obligation refers to the mutual duties created within the contract, and transparency, while important, is not the established legal principle that governs the interplay of honesty between the insurer and the insured.

**5. Who can be classified as an agent in the insurance process?**

- A. A customer purchasing insurance**
- B. A licensed person collecting claims**
- C. A person soliciting sales of insurance products**
- D. An underwriter evaluating risks**

In the context of the insurance process, an agent is primarily defined as an individual who represents an insurance company and is involved in activities such as selling and soliciting insurance products. Agents are typically licensed professionals who work to help potential policyholders choose appropriate insurance coverage, which makes them pivotal in the insurance distribution channel. By definition, an agent acts on behalf of the insurer and plays a critical role in connecting the insurer to the customers, facilitating the sale of insurance policies. This includes providing advice, answering questions about various policies, and navigating clients through the application process. In contrast, the other roles mentioned—such as customers, claims collectors, and underwriters—serve different functions within the insurance industry. Customers are the individuals seeking to purchase insurance, claims collectors assist in the claims process but do not typically engage in sales, and underwriters focus on assessing risks and determining coverage terms, rather than selling insurance. Thus, the role that aligns with the definition of an agent is the individual soliciting sales of insurance products.

**6. The act of providing false information to an insurer for personal gain is known as what?**

- A. Negligence**
- B. Insurance fraud**
- C. Moral hazard**
- D. Risk management**

The act of providing false information to an insurer for personal gain is known as insurance fraud. This is a serious offense that undermines the integrity of the insurance system and can lead to significant financial losses for insurers and consequently, higher premiums for honest policyholders. Insurance fraud can take many forms, including exaggerating claims, omitting information on applications, or staging events to collect benefits. By engaging in such deceptive practices, individuals not only violate their legal and ethical obligations but also contribute to a larger cycle of mistrust within the insurance industry. The consequences for committing insurance fraud can be severe, ranging from criminal charges to the loss of insurance coverage and the inability to obtain future policies. Understanding the implications of insurance fraud is essential for both consumers and insurance professionals, as it reinforces the importance of transparency and honesty in dealings with insurers.

**7. What is the time frame for an insured to notify an insurer of a claim after a loss?**

- A. 10 days**
- B. 20 days**
- C. 30 days**
- D. The policy year**

The correct answer indicates that the insured typically has a period of 20 days to notify the insurer of a claim after a loss occurs. This time frame is generally outlined in various insurance policies to ensure timely communication and prompt handling of the claim process. Prompt notification allows insurers to start their investigation and assessment of the claim, which is essential for a fair and efficient resolution. The choice of 20 days reflects a standard that balances the need for the insured to gather information regarding the loss and the insurer's right to timely closure of claims for adequate risk management and financial planning. Adhering to this time frame helps both parties to maintain the integrity of the insurance contract and facilitates a smoother claims process. Other time frames like 10 days or 30 days may appear in different contexts or specific types of insurance, but in a general sense, the 20-day period is often the norm set forth in many standard policies. The option of 'the policy year' is not applicable, as it refers to the duration of coverage rather than the notification period for a specific claim.

**8. Which term refers to the competition among insurers to retain business?**

- A. Coercion**
- B. Competitive Advantage**
- C. Boycott**
- D. Market Competition**

The term that refers to the competition among insurers to retain business is "Market Competition." This concept encompasses the strategies and activities that insurance companies engage in to maintain their client base and attract new customers in a competitive environment. Insurers may leverage various tactics, such as price adjustments, enhanced customer service, product offerings, and marketing campaigns, to differentiate themselves from competitors and gain a stronger position in the market. Understanding market competition is crucial for insurers as it directly impacts their ability to meet organizational goals and respond effectively to changes in consumer demand and industry trends. Additionally, effective market competition can lead to better outcomes for consumers, such as more options and potentially lower prices. The other options do not accurately describe this scenario. Coercion implies using force or intimidation, which is not a competitive tactic used in the marketplace. Competitive Advantage refers to the conditions that allow one business to perform better than its competitors, but it does not specifically describe the process of competition itself. A boycott involves a group refusing to engage with a business to express dissatisfaction, which does not relate to how insurers compete to retain business.

**9. Who is normally offered credit accident and health insurance?**

- A. Any borrower**
- B. Only individuals under 30 years of age**
- C. The primary borrower actively at work**
- D. Secondary borrowers**

Credit accident and health insurance is typically offered to the primary borrower who is actively working. This insurance is designed to cover the borrower's loan payments in the event of certain health-related issues or accidents that prevent them from earning income. The rationale behind this focus on the primary borrower is to protect the lender's investment by ensuring that the borrower can meet their financial obligations even in unforeseen circumstances. Since this insurance is primarily aimed at covering the financial risk associated with the repayment of the loan, it makes sense for it to be offered to someone who is actively employed and therefore likely to have a consistent income. Active employment indicates that the borrower is presently capable of fulfilling the loan requirements, making them a suitable candidate for this type of coverage. In contrast, options that suggest other groups, such as only individuals under 30 years of age or secondary borrowers, would not address the primary intention of this insurance, which is to safeguard the lender's interests through the main borrower.

**10. What might NOT be a reason for a claim denial in insurance?**

- A. Policy exclusions**
- B. Failure to pay premiums**
- C. Excess claims by the insured**
- D. Inadequate coverage levels**

A claim denial can occur for various reasons based on the terms and conditions specified in the insurance policy. Among the options presented, excessive claims by the insured typically do not directly lead to a denial of a claim. Insurers usually look at the circumstances of each claim independently, and claims are generally assessed based on their individual merit, adherence to policy guidelines, and the specifics of the loss incurred. While the other options clearly outline valid reasons for claim denial, such as policy exclusions (certain events or damages not covered by insurance), failure to pay premiums (which would void coverage), and inadequate coverage levels (where the amount of coverage does not meet the loss experienced), the idea that an insured can be penalized simply for having multiple claims does not automatically justify a denial. Instead, the insurer might evaluate the nature of each claim and the coverage applicable to them, focusing instead on the conditions outlined in the policy rather than penalizing the insured for prior claims.



## 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](mailto:hello@examzify.com).**

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

**<https://cunainsuranceproducer.examzify.com>**

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