

Georgia Life and Health Insurance Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

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- 1. What is primarily measured by morbidity rates?**
 - A. The ability to recover from illness**
 - B. The incidence of disability across various demographics**
 - C. The prevalence of illness among a population**
 - D. The ratio of insured individuals to those uninsured**
- 2. What classification applies to applicants with a lower expectation of incurring losses?**
 - A. Standard Risk**
 - B. Preferred Risk**
 - C. Substandard Risk**
 - D. High-Risk**
- 3. What is a consumer report in the context of insurance?**
 - A. A detailed financial statement**
 - B. A review of an applicant's health history**
 - C. A written and/or oral statement about a consumer**
 - D. An insurance claim report**
- 4. What term is used to describe the amounts an insured must pay before their insurer starts to cover costs?**
 - A. Premiums**
 - B. Out-of-pocket costs**
 - C. Co-payments**
 - D. Endorsements**
- 5. What does rescission entail regarding an insurance policy?**
 - A. The voluntary termination by the insured**
 - B. Universal cancellation due to age of policy**
 - C. Termination due to misrepresentation or fraud**
 - D. A routine review process of active policies**
- 6. What is the definition of a death benefit in life insurance?**
 - A. The total premiums paid by the insured**
 - B. The amount payable upon the insured's death**
 - C. An annual payout to the insured**
 - D. A policy loan amount**

7. What is the timeframe referred to as when an employee must sign up for a contributory group health plan?

- A. Eligibility Period**
- B. Enrollment Period**
- C. Sign-Up Period**
- D. Application Period**

8. What type of insurance is designed to fill the gaps in Medicare coverage?

- A. Medicare Part B**
- B. Medicare Advantage**
- C. Medicare Supplement Insurance**
- D. Medicaid**

9. What is the term for withholding known facts that can void an insurance contract?

- A. Misrepresentation**
- B. Concealment**
- C. Fraud**
- D. Omission**

10. What type of benefits are mandated by state law to be paid to an employee by an employer in the case of injury, disability, or death due to an on-the-job hazard?

- A. Workers Compensation**
- B. Disability Insurance**
- C. Health Benefits**
- D. Life Insurance**

Answers

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

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Explanations

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1. What is primarily measured by morbidity rates?

- A. The ability to recover from illness
- B. The incidence of disability across various demographics
- C. The prevalence of illness among a population**
- D. The ratio of insured individuals to those uninsured

Morbidity rates primarily measure the prevalence of illness among a population. This statistic is crucial in public health and insurance as it helps to determine how widespread certain diseases or health conditions are within specific groups or communities. By understanding morbidity rates, insurers and healthcare providers can assess the overall health of a population, allocate resources effectively, and design relevant healthcare plans or interventions. Morbidity encompasses not just the incidence of new cases of disease but also includes existing cases, which informs health service planning and policy-making. Understanding the prevalence can impact insurance premiums, coverage decisions, and risk assessments, shaping how insurance products are structured to meet the needs of those who may be affected by various health issues.

2. What classification applies to applicants with a lower expectation of incurring losses?

- A. Standard Risk
- B. Preferred Risk**
- C. Substandard Risk
- D. High-Risk

The classification that applies to applicants with a lower expectation of incurring losses is known as Preferred Risk. This designation is given to individuals who are considered to be less likely to require insurance benefits based on their health, lifestyle, and medical history. Insurance companies evaluate applicants to determine their risk levels, and those classified as Preferred Risk typically have favorable factors such as good health, non-smoking status, and lower risk hobbies. As a result, these individuals are offered lower premiums and better policy terms, reflecting their lower likelihood of claiming insurance benefits. This classification system helps insurers manage risk effectively while providing incentives for individuals to maintain healthier lifestyles.

3. What is a consumer report in the context of insurance?

- A. A detailed financial statement
- B. A review of an applicant's health history
- C. A written and/or oral statement about a consumer**
- D. An insurance claim report

In the context of insurance, a consumer report is a written and/or oral statement about a consumer that can include various types of information, such as credit history, employment status, and other relevant data that may affect the underwriting process. This report is utilized by insurers to assess the risk associated with insuring a person and to determine eligibility for coverage, as well as the pricing of premiums. Consumer reports help provide a broader picture of the applicant's background, which is essential for insurance companies to make informed decisions. They can encompass reports from credit agencies and other entities, giving insurers insight into an applicant's financial behavior and reliability. The other options do not accurately describe a consumer report in this context. A detailed financial statement specifically relates to an individual's finances rather than a broader evaluation. A review of an applicant's health history is more precisely categorized as a medical report, not a consumer report. An insurance claim report pertains to specific claims made and paid, which is different from the general background information collected during the underwriting process. Thus, the definition of a consumer report aligns closely with the correct answer.

4. What term is used to describe the amounts an insured must pay before their insurer starts to cover costs?

- A. Premiums
- B. Out-of-pocket costs**
- C. Co-payments
- D. Endorsements

The correct term to describe the amounts an insured must pay before their insurer starts to cover costs is "out-of-pocket costs." This encompasses any expenses that the insured must cover themselves, including deductibles, co-payments, and co-insurance, before the insurance policy kicks in to pay for covered services. While co-payments are a specific type of out-of-pocket cost that refers to a fixed amount paid for particular services (like doctor visits), they don't encompass all costs leading up to the insurer's coverage.

Premiums are periodic payments made to maintain the insurance policy but do not relate to the costs paid at the time of service. Endorsements refer to changes or additions made to an insurance policy but are not a direct payment terminology related to insured costs. Understanding the broad category of out-of-pocket costs is essential in grasping how insurance works regarding the financial responsibilities of the insured individual.

5. What does rescission entail regarding an insurance policy?

- A. The voluntary termination by the insured
- B. Universal cancellation due to age of policy
- C. Termination due to misrepresentation or fraud**
- D. A routine review process of active policies

Rescission regarding an insurance policy specifically involves the termination of the policy due to misrepresentation or fraud. This means that if an insurer discovers that the insured provided false information or failed to disclose vital facts during the application process, it has the right to cancel the insurance policy. This is critical because insurance relies heavily on the principle of utmost good faith, meaning that both the insurer and insured must be honest and transparent in their dealings. When misrepresentation or fraud is identified, the insurer may determine that it would not have issued the policy under those circumstances or would have done so under different terms. This concept protects the integrity of the insurance market, ensuring that only accurate and truthful information is used in underwriting decisions. If an insurer can prove that misrepresentation occurred, they can rescind the policy, effectively nullifying any coverage from its inception. Understanding this principle is important for both insurers and policyholders, as it highlights the seriousness of truthful disclosures when applying for insurance.

6. What is the definition of a death benefit in life insurance?

- A. The total premiums paid by the insured
- B. The amount payable upon the insured's death**
- C. An annual payout to the insured
- D. A policy loan amount

The definition of a death benefit in life insurance refers to the amount payable upon the insured's death. This benefit is a key feature of life insurance policies, designed to provide financial security and support to the beneficiaries upon the passing of the insured individual. The death benefit can help cover various expenses such as funeral costs, outstanding debts, and ongoing living expenses for the insured's dependents. In contrast, other options do not accurately define the death benefit. The total premiums paid refers to the cumulative amount the policyholder has invested in the policy over time, rather than the amount received upon death. An annual payout to the insured typically pertains to certain types of life insurance policies that offer living benefits, rather than a death benefit. A policy loan amount represents funds that can be borrowed against the cash value of a permanent life insurance policy but does not relate to what beneficiaries receive upon the insured's death. Therefore, the accurate understanding of a death benefit is essential for identifying the primary purpose of life insurance.

7. What is the timeframe referred to as when an employee must sign up for a contributory group health plan?

- A. Eligibility Period**
- B. Enrollment Period**
- C. Sign-Up Period**
- D. Application Period**

The timeframe when an employee must sign up for a contributory group health plan is commonly referred to as the Enrollment Period. This period is crucial because it determines when employees can enroll in the health plan offered by their employer, particularly for contributory plans where the employee shares the cost of premiums. Employees typically have a set window of time to make their elections, and if they miss this window, they may have to wait until the next enrollment period or qualify for special enrollment opportunities. The Enrollment Period ensures that employees are making informed decisions about their health coverage at the right time and helps the insurance provider manage risk by having a defined timeline for new participants. Understanding this timeframe is essential for employees to maintain adequate health coverage while also aligning with their employer's benefits schedule.

8. What type of insurance is designed to fill the gaps in Medicare coverage?

- A. Medicare Part B**
- B. Medicare Advantage**
- C. Medicare Supplement Insurance**
- D. Medicaid**

Medicare Supplement Insurance, often referred to as Medigap, is specifically designed to fill the gaps in Medicare coverage. Medicare itself, while it provides a foundation of health benefits, does not cover all healthcare costs. For example, beneficiaries often face out-of-pocket expenses such as copayments, coinsurance, and deductibles that can be significant. Medigap policies are issued by private insurance companies and can help cover these additional costs, thereby providing more comprehensive financial protection for those enrolled in Medicare. The Medigap policies work alongside original Medicare (Parts A and B) and are standardized plans that vary in benefits but are regulated to ensure a certain level of coverage. This supplementary nature allows individuals to better manage their healthcare expenses and avoid unexpected financial burdens. Other options listed do not serve the same purpose. Medicare Part B provides specific coverage for outpatient care and preventive services, but it does not address the gaps directly. Medicare Advantage plans offer a different model by including both Medicare Part A and Part B benefits along with additional services but aren't specifically meant to be a supplementary buffer for costs not covered by Medicare. Medicaid, on the other hand, is a state and federal program that assists low-income individuals with medical costs but does not function as a supplement to

9. What is the term for withholding known facts that can void an insurance contract?

- A. Misrepresentation**
- B. Concealment**
- C. Fraud**
- D. Omission**

The term for withholding known facts that can void an insurance contract is "concealment." In the context of insurance, concealment refers to the failure of the policyholder to disclose important information that may affect the insurer's decision to issue a policy or determine the terms of coverage. If an individual intentionally hides relevant facts, it can result in the insurer being misled, which might ultimately lead to the denial of a claim or the cancellation of the insurance policy. Concealment is a serious issue because insurance contracts are based on the principle of utmost good faith, requiring both parties to be honest and transparent. When one party conceals material facts, it undermines this principle and can lead to significant consequences, including the voiding of the contract. Understanding concealment is crucial for those studying for the Georgia Life and Health Insurance Exam, as it emphasizes the importance of full disclosure in the insurance application process.

10. What type of benefits are mandated by state law to be paid to an employee by an employer in the case of injury, disability, or death due to an on-the-job hazard?

- A. Workers Compensation**
- B. Disability Insurance**
- C. Health Benefits**
- D. Life Insurance**

The correct answer is the type of benefits known as **Workers Compensation**. This is a state-mandated program that provides financial compensation and medical benefits to employees who suffer job-related injuries, disabilities, or death as a result of accidents or hazards encountered in the workplace. Workers Compensation serves as a form of insurance that ensures employees receive necessary support without needing to prove fault or negligence on the part of the employer. These benefits typically cover medical expenses, rehabilitation costs, and a portion of lost wages during recovery. This system is designed to protect both the employees and employers in the event of workplace injuries, ensuring that workers can receive prompt medical treatment and financial assistance while also limiting liability for the employer. Disability insurance refers to benefits that provide income support in the case an employee is unable to work due to an illness or injury, but it is not specifically tied to on-the-job incidents as Workers Compensation is. Health benefits generally cover medical expenses but do not focus on workplace injuries specifically. Life insurance provides financial support to beneficiaries in the event of an insured individual's death but does not directly relate to the workplace hazard context that Workers Compensation addresses.

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://galifehealthinsurance.examzify.com>

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

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