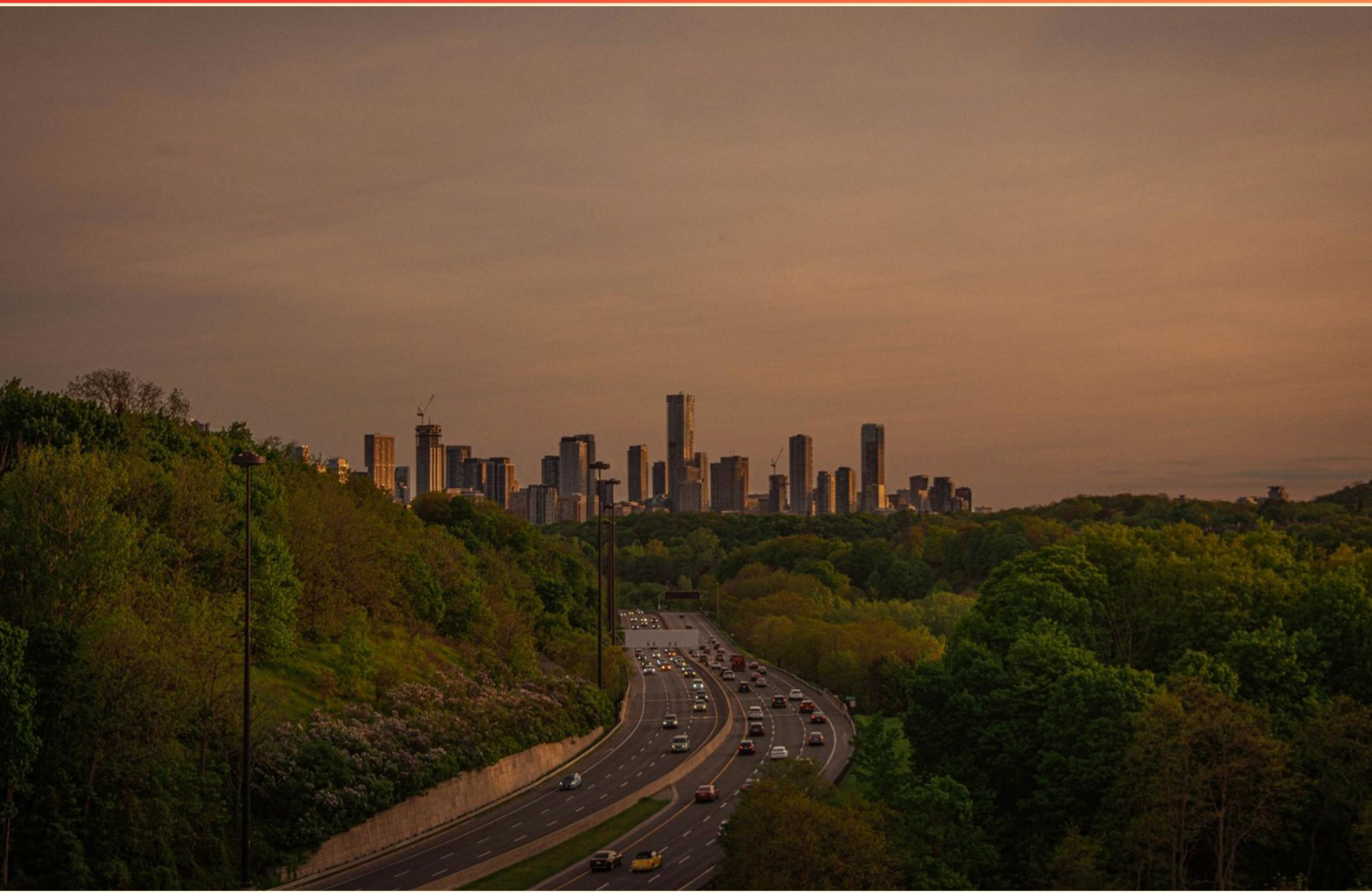


GEORGIA LIFE AND HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

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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. What type of risk can only result in a loss or no change?**
 - A. Speculative Risk
 - B. Pure Risk
 - C. Financial Risk
 - D. Operational Risk
- 2. What is referred to as the amount a physician or supplier actually bills for a particular service or supply?**
 - A. Fee schedule
 - B. Actual charge
 - C. Service cost
 - D. Billing rate
- 3. How long can an insured continue group health care benefits under COBRA after employment termination?**
 - A. 12 months
 - B. 18 months
 - C. 24 months
 - D. 36 months
- 4. What is an Attending Physician Statement (APS)?**
 - A. A statement usually obtained from the applicant's doctor
 - B. A claim form submitted for insurance payment
 - C. A document required for insurance policy approval
 - D. A summary of the applicant's medical history
- 5. What term describes the practice of insurers pressuring applicants through dubious means?**
 - A. Coercion
 - B. Compulsion
 - C. Influence
 - D. Manipulation

6. What happens when an employee does not report a workplace injury in a timely manner?

- A. Benefits may still be paid
- B. Workers compensation claim may be denied
- C. Employer is liable for all expenses
- D. Employee receives additional benefits

7. What type of report provides information on a consumer's character and habits?

- A. Credit Report
- B. Investigative Consumer Report
- C. Health Report
- D. Financial Report

8. What term describes a selection of health care benefits from which an employee may choose the ones that he/she needs?

- A. Cafeteria Plan
- B. Flexible Benefits Plan
- C. Health Savings Account
- D. Employee Assistance Program

9. What is the major concern addressed by reinsurers?

- A. Increasing the market share of insurance
- B. Covering losses incurred by agents
- C. Mitigating risks taken on by primary insurers
- D. Eliminating fraud in insurance claims

10. Which of the following best describes Basic Medical Expense Insurance?

- A. Insurance that covers major illnesses only
- B. Insurance that provides limited benefits for medical costs
- C. Insurance that covers all medical expenses without limits
- D. Insurance covering only hospital stays

Answers

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

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Explanations

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1. What type of risk can only result in a loss or no change?

- A. Speculative Risk
- B. Pure Risk**
- C. Financial Risk
- D. Operational Risk

Pure risk is defined as a type of risk that can only result in a loss or no change, making it distinct from other types of risk. It pertains to situations where there is a potential for negative outcomes, such as accidents, natural disasters, illness, or death, but no opportunity for financial gain. This contrasts with speculative risk, which involves scenarios where there is both the possibility of loss and the chance for gain—like investing in the stock market or starting a business. In the context of insurance, pure risks are the only type traditionally covered by insurance policies because they focus on the protection against losses rather than opportunities for profit. Understanding pure risk is crucial for assessing insurance needs and coverage options, as it directly impacts how individuals and businesses manage potential threats to their assets and well-being.

2. What is referred to as the amount a physician or supplier actually bills for a particular service or supply?

- A. Fee schedule
- B. Actual charge**
- C. Service cost
- D. Billing rate

The term that describes the amount a physician or supplier actually bills for a particular service or supply is the "actual charge." This amount represents the specific dollar figure that a medical provider lists on an invoice for the services rendered or supplies provided to a patient or insurance company. Since actual charges can vary significantly between different providers or geographic areas, they are important for understanding the financial aspects of healthcare costs. In contrast, a fee schedule is a pre-established list of fees that a healthcare provider may charge for specific services, which often is used in determining payouts by insurance companies. The concept of service cost is broader and might refer to the total expense incurred in providing care, including overhead, not just the amount billed. The billing rate typically pertains to a standard charged rate rather than the specific amount charged for individual services. Therefore, the most accurate choice for the amount billed by providers for services is indeed the actual charge.

3. How long can an insured continue group health care benefits under COBRA after employment termination?

- A. 12 months
- B. 18 months**
- C. 24 months
- D. 36 months

The correct duration for continuation of group health care benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA) is 18 months following employment termination. COBRA is a federal law that allows employees and their families to retain their group health insurance coverage for a specific time after certain events, such as job loss, reduction in work hours, or other qualifying events. When an employee is terminated, they can generally extend their health benefits for up to 18 months. This provision is designed to give individuals time to transition to new employment or alternative insurance options without losing their health coverage immediately after the loss of their job. The option indicating 12 months is incorrect because the length of coverage under COBRA is specifically set at 18 months for job loss. The 24-month duration is typically applicable in certain circumstances where a second qualifying event occurs during the initial period or if a qualified beneficiary is disabled when the coverage is initiated. The 36-month option refers to coverage extensions available to dependents under specific circumstances, such as divorce or death of the covered employee, but does not apply to the scenarios related to termination of employment alone. In summary, the correct answer reflects the specific provision in COBRA for extending health benefits due to termination, which

4. What is an Attending Physician Statement (APS)?

- A. A statement usually obtained from the applicant's doctor**
- B. A claim form submitted for insurance payment
- C. A document required for insurance policy approval
- D. A summary of the applicant's medical history

An Attending Physician Statement (APS) is specifically a statement that is usually obtained from the applicant's doctor to provide important medical information necessary for underwriting insurance policies. This document is often required by insurers to help assess the risks associated with issuing a policy, particularly for life and health insurance. The APS contains details about the applicant's medical history, treatment plans, and current health status directly from the treating physician, which helps underwriters make informed decisions about coverage and premiums. The definition of an APS highlights its role as a key component in the underwriting process, ensuring that the insurer has a clear understanding of the applicant's health and any potential risks. This specificity in the function of the APS distinguishes it from other related documents, such as claim forms or general medical history summaries, which serve different purposes in the insurance framework.

5. What term describes the practice of insurers pressuring applicants through dubious means?

- A. Coercion**
- B. Compulsion
- C. Influence
- D. Manipulation

The term that best describes the practice of insurers pressuring applicants through dubious means is coercion. Coercion refers to the use of force, intimidation, or threats to compel someone to act in a certain way or to make a decision they might not otherwise have made. In the context of insurance, this can manifest as undue pressure or misleading tactics that lead an applicant to purchase a policy or agree to terms that are not in their best interest. This practice is unethical and can lead to serious consequences for both the insurer and the applicant. Understanding coercion is particularly important in the insurance industry to ensure that policies are sold based on informed consent and genuine need, rather than through manipulation or intimidation. By recognizing coercion, applicants can be more mindful of their rights and protections against unscrupulous practices.

6. What happens when an employee does not report a workplace injury in a timely manner?

- A. Benefits may still be paid
- B. Workers compensation claim may be denied**
- C. Employer is liable for all expenses
- D. Employee receives additional benefits

Timely reporting of workplace injuries is crucial in the context of workers' compensation. When an employee fails to report an injury promptly, it can lead to complications in the claims process. A significant consequence of not reporting an injury in a timely manner is that the workers' compensation claim may be denied. Timely notification allows the employer to investigate the incident while details are fresh and enables a faster response to the claim. Each state has specific laws regarding the timeframe in which an injury must be reported to qualify for benefits. Failing to adhere to these timelines can result in the denial of the claim, as the insurer may question the validity of the injury due to the delay in reporting. This is why it's emphasized that employees should report any injuries as soon as they occur to ensure they receive the benefits they are entitled to under their state's workers' compensation laws.

7. What type of report provides information on a consumer's character and habits?

- A. Credit Report
- B. Investigative Consumer Report**
- C. Health Report
- D. Financial Report

The investigative consumer report is designed to gather information about a consumer's character and habits. This type of report typically includes insights into a person's lifestyle, behavior, and reputation, which can be particularly relevant for insurers when evaluating an applicant's risk profile. It can include details sourced from interviews with acquaintances, neighbors, or professional contacts, providing a more comprehensive view of the individual beyond just their financial status. In contrast, a credit report primarily focuses on a consumer's financial history, detailing credit scores, outstanding debts, and repayment history. A health report relates specifically to an individual's medical history and health status, which does not cover aspects of character or habits. A financial report also centers around monetary matters and assets, missing the character and lifestyle elements assessed in an investigative consumer report. This distinction emphasizes why the investigative consumer report is the correct choice for obtaining insights into a person's character and habits.

8. What term describes a selection of health care benefits from which an employee may choose the ones that he/she needs?

- A. Cafeteria Plan**
- B. Flexible Benefits Plan
- C. Health Savings Account
- D. Employee Assistance Program

The term that describes a selection of health care benefits from which an employee may choose the ones that he or she needs is known as a Cafeteria Plan. This type of plan provides employees with a range of benefits and allows them to customize their benefits package according to their individual needs and personal circumstances. Employees can typically select from various options such as health insurance, dental and vision coverage, and other benefits, which enables them to tailor their benefits to fit their lifestyle, family situation, and financial priorities. In a Cafeteria Plan, the employer typically allocates a set amount of money or credits that employees can use to purchase their selected benefits. This flexibility is key to appealing to a diverse workforce, as it recognizes that not all employees have the same health care requirements or preferences. Alternative options such as Flexible Benefits Plans also offer some level of customization, but Cafeteria Plans are specifically characterized by the range of choices provided. Health Savings Accounts are designed to allow individuals to save pre-tax dollars for medical expenses but do not provide a selection of benefits themselves. Employee Assistance Programs focus on providing support services to employees rather than allowing them to choose among multiple health care benefits. Thus, the definitive selection process inherent to Cafeteria Plans sets it apart as

9. What is the major concern addressed by reinsurers?

- A. Increasing the market share of insurance
- B. Covering losses incurred by agents
- C. Mitigating risks taken on by primary insurers**
- D. Eliminating fraud in insurance claims

Reinsurers primarily focus on mitigating risks taken on by primary insurers. Reinsurance serves as a form of insurance for insurance companies, allowing them to protect themselves from significant losses that could arise from catastrophic claims or unforeseen events. By transferring a portion of their risk to reinsurers, primary insurers can stabilize their loss experience, maintain their capital reserves, and protect their solvency. This risk mitigation helps ensure that they are not overly exposed to certain high-risk policies or concentrated losses, allowing them to operate more effectively in the market. The other options pertain to aspects of the insurance industry but do not capture the primary role of reinsurers. For example, increasing market share relates more to the strategies of insurance companies seeking to expand their customer base, covering losses incurred by agents generally concerns compensation structures, and eliminating fraud is a broader industry concern that usually involves various stakeholders, including primary insurers and regulatory bodies, rather than being a direct focus of reinsurers.

10. Which of the following best describes Basic Medical Expense Insurance?

- A. Insurance that covers major illnesses only
- B. Insurance that provides limited benefits for medical costs**
- C. Insurance that covers all medical expenses without limits
- D. Insurance covering only hospital stays

Basic Medical Expense Insurance is characterized by its provision of limited benefits to cover various medical costs. This type of insurance is designed to alleviate some of the financial burdens associated with routine medical expenses such as doctor visits, outpatient care, and preventive treatments. However, the coverage is not comprehensive; it typically includes a cap on benefits, making it essential for enrollees to understand what is covered and the extent of that coverage. This structure allows consumers to access necessary medical care at a more affordable rate without extensive coverage for all expenses or major illnesses. In contrast to the characteristics of Basic Medical Expense Insurance, options that mention major illnesses or comprehensive coverage do not reflect the limited nature of the benefits provided. Similarly, coverage that applies solely to hospital stays fails to capture the broader scope of medical expenses that Basic Medical Expense Insurance typically addresses, albeit with limitations. Thus, the description of Basic Medical Expense Insurance as providing limited benefits for medical costs aptly conveys its fundamental purpose within the health insurance landscape.

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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