

# Health and Accident 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. If an employee contributes 50% toward the disability plan premium provided by an employer, what would be considered the taxable income of a \$1,000 monthly disability benefit?**
  - A. \$500
  - B. \$1,000
  - C. \$300
  - D. \$700
- 2. When are group disability benefits considered to be tax-free to the insured?**
  - A. When the employer pays the full premiums
  - B. When the recipient pays the premiums
  - C. When the benefits exceed the premiums
  - D. When the benefits are paid directly to the employer
- 3. What is the purpose of an insurance policy's grace period?**
  - A. To allow for premium increases without notice
  - B. To provide time for policyholders to file claims
  - C. To allow the policyholder a specified time to pay overdue premiums without losing coverage
  - D. To give the insured time to decide on additional coverage options
- 4. What is the purpose of long-term care insurance?**
  - A. To provide immediate coverage for hospitalization only
  - B. To cover extended care costs for elderly individuals or those with chronic illnesses
  - C. To pay for regular medical check-ups and preventive care
  - D. To insure individuals against accidental death
- 5. What is the significance of the grace period in insurance contracts?**
  - A. It allows policyholders to make late claims
  - B. It permits payments after the due date without losing coverage
  - C. It extends the overall policy duration
  - D. It modifies premium rates

**6. What is the definition of a "claim" in health insurance?**

- A. A request for preapproval of medical treatments**
- B. A request for payment from the insurer for a covered health care service**
- C. A statement of insurance benefits provided to the insured**
- D. A notification of policy cancellation**

**7. What does "out-of-pocket maximum" refer to?**

- A. The total premium paid each year**
- B. The limit on the amount an insurer will pay for covered services**
- C. The highest amount the insured must pay for covered services in a policy period**
- D. The maximum deductible allowed by law**

**8. What document is issued to each employee of an employer health plan?**

- A. Policy**
- B. Certificate**
- C. Enrollment form**
- D. Insurance card**

**9. What type of policy would most likely include a provision for tail coverage?**

- A. Whole life insurance**
- B. Term life insurance**
- C. Claims-made malpractice insurance**
- D. Universal health insurance**

**10. Who is referred to as a "beneficiary" in a health insurance policy?**

- A. The policyholder who pays for coverage**
- B. An individual designated to receive policy benefits**
- C. The insurance agent selling the policy**
- D. The healthcare provider giving the medical services**

## **Answers**

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

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## **Explanations**

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**1. If an employee contributes 50% toward the disability plan premium provided by an employer, what would be considered the taxable income of a \$1,000 monthly disability benefit?**

- A. \$500**
- B. \$1,000**
- C. \$300**
- D. \$700**

When determining the taxable income from a disability benefit, the key factor is the proportion of the premium that the employee pays. In this case, since the employee contributes 50% of the premium for the disability plan, this portion represents the employee's investment in the policy. Disability benefits are generally taxable to the extent that the premiums were not paid by the employee. Since the employee is covering half of the premium cost, they have effectively paid for half of their benefits. Therefore, the benefit amount taxable to the employee would reflect the employer's contribution, which covers the other 50%. In this scenario, with a \$1,000 monthly disability benefit and the employee contributing 50% toward the premium, only the half paid by the employer is subject to taxation. This results in a taxable income of \$500, which represents the amount corresponding to the employer's share of the premium. To summarize, the amount of the taxable income from the disability benefits directly correlates to the proportion of the premium that the employer covers, and since the employer contributes 50% of the premium in this case, the correct taxable income is \$500.

**2. When are group disability benefits considered to be tax-free to the insured?**

- A. When the employer pays the full premiums**
- B. When the recipient pays the premiums**
- C. When the benefits exceed the premiums**
- D. When the benefits are paid directly to the employer**

Group disability benefits are considered tax-free to the insured when the recipient pays the premiums. This is because, under tax law, when the insured individual pays the premiums for their disability coverage, they are effectively funding their own benefits. As a result, any benefits received from that coverage are not considered taxable income, since they are viewed as a return of the individual's own contributions. This tax treatment provides a significant incentive for employees to invest in their own disability insurance, as it means that in the event of a claim, they won't have to worry about taxes reducing the financial support they receive during a period of disability. This contrasts with situations where an employer pays for the premiums, which could result in taxable benefits for the employee depending on specific circumstances and regulations.

### 3. What is the purpose of an insurance policy's grace period?

- A. To allow for premium increases without notice
- B. To provide time for policyholders to file claims
- C. To allow the policyholder a specified time to pay overdue premiums without losing coverage**
- D. To give the insured time to decide on additional coverage options

The grace period in an insurance policy serves the important function of giving policyholders a specified amount of time to make overdue premium payments without risking the loss of their coverage. This period typically starts after the premium due date and allows individuals to catch up on missed payments, thereby maintaining their insurance protection. This feature is crucial since it acknowledges that financial situations can change, and sometimes individuals may need a little more time to gather the necessary funds. Without a grace period, policyholders could face immediate lapses in their coverage as soon as a payment is missed, potentially leaving them vulnerable in times of need. The other choices focus on aspects not related to the primary function of the grace period. For instance, while premium increases and filing claims are integral to insurance policies, they are not the role of the grace period. Additionally, considering further coverage options, while important, falls outside the scope of the immediate financial assistance that the grace period provides for premium payments. Hence, the correct function of the grace period is to prevent loss of coverage due to delayed payments.

### 4. What is the purpose of long-term care insurance?

- A. To provide immediate coverage for hospitalization only
- B. To cover extended care costs for elderly individuals or those with chronic illnesses**
- C. To pay for regular medical check-ups and preventive care
- D. To insure individuals against accidental death

Long-term care insurance is specifically designed to cover the costs associated with extended care services that individuals may need due to chronic illnesses, disabilities, or age-related conditions. This type of insurance is particularly important as it helps to pay for services that assist individuals with daily activities, such as bathing, dressing, eating, and other forms of personal care. Unlike traditional health insurance, which typically focuses on acute medical conditions and hospitalization, long-term care insurance addresses the ongoing support that might be necessary for individuals who require assistance over an extended period of time. The other options presented do not correctly describe the purpose of long-term care insurance. For instance, coverage for hospitalization is not the focus of this type of insurance, as it pertains solely to immediate medical care rather than long-term assistance. Similarly, while regular check-ups and preventive care are essential aspects of health maintenance, they are typically covered by standard health insurance rather than long-term care insurance. Lastly, insuring against accidental death falls outside the realm of long-term care, which is concerned with providing support rather than death benefits.

## 5. What is the significance of the grace period in insurance contracts?

- A. It allows policyholders to make late claims**
- B. It permits payments after the due date without losing coverage**
- C. It extends the overall policy duration**
- D. It modifies premium rates**

The significance of the grace period in insurance contracts is that it provides a critical safety net for policyholders by permitting payments after the due date without the loss of coverage. This means that if a policyholder is unable to pay their premium by the due date, the grace period allows for a specific amount of time—usually 10 to 30 days—during which they can still make their payment without placing their coverage at risk. This is especially important as it offers policyholders peace of mind, knowing that they have a buffer period during which they can fulfill their payment obligations and maintain their insurance protection. Options that suggest making late claims, extending policy duration, or modifying premium rates do not accurately describe what the grace period is intended for. The grace period does not allow claims to be filed late; it focuses solely on premium payments. It also does not change the length of the policy or alter the rates, which are generally fixed for the life of the policy or adjusted at renewal, depending on the insurer's guidelines. Therefore, the grace period serves the vital role of ensuring that policyholders do not inadvertently lose their coverage due to minor payment delays.

## 6. What is the definition of a "claim" in health insurance?

- A. A request for preapproval of medical treatments**
- B. A request for payment from the insurer for a covered health care service**
- C. A statement of insurance benefits provided to the insured**
- D. A notification of policy cancellation**

In health insurance, a "claim" refers specifically to a request for payment from the insurer for a covered health care service. When an insured person receives medical care, the health care provider typically submits a claim to the insurance company to seek reimbursement for the services provided. This process ensures that the covered expenses are paid according to the terms of the insurance policy. This definition encompasses the essence of how health insurance functions—claim submissions are integral to the operation of the insurance system, allowing insured individuals to receive necessary health services without bearing the full financial burden upfront. The claim process is foundational in establishing the responsibilities of the insurer based on the coverage outlined in the policy. The other options provide explanations of related concepts but do not accurately define a claim. For instance, requesting preapproval of medical treatments refers to prior authorization processes, not to a claim itself. A statement of insurance benefits relates to what the insured is entitled to under their policy but does not constitute a request for payment. Lastly, a notification of policy cancellation does not pertain to claims at all, as it deals with the status of the insurance contract rather than a financial transaction related to care.

## 7. What does "out-of-pocket maximum" refer to?

- A. The total premium paid each year
- B. The limit on the amount an insurer will pay for covered services
- C. The highest amount the insured must pay for covered services in a policy period**
- D. The maximum deductible allowed by law

The concept of "out-of-pocket maximum" refers to the highest amount the insured must pay for covered services within a specific policy period, typically a year. This amount includes various cost-sharing components such as deductibles, copayments, and coinsurance. Once the insured reaches this limit, the insurance company covers 100% of the costs for any additional covered services for the remainder of the policy period. This mechanism is essential for protecting consumers from excessive healthcare costs. It provides a safeguard that ensures individuals do not face financial ruin due to high medical expenses. Understanding the out-of-pocket maximum is critical for policyholders as it helps them manage their healthcare budgets and plan for potential medical expenses. Other options provided do not accurately capture the essence of the out-of-pocket maximum. For instance, total premiums refer to what is paid for insurance coverage itself, while limits set by insurers on the amount they pay do not reflect the insured's financial obligations. Additionally, the maximum deductible relates to the initial costs an insured must pay before the insurance begins to cover expenses, which is a different concept than the cumulative costs represented by the out-of-pocket maximum.

## 8. What document is issued to each employee of an employer health plan?

- A. Policy
- B. Certificate**
- C. Enrollment form
- D. Insurance card

The document that is issued to each employee of an employer health plan is the certificate. This certificate serves as proof of coverage and outlines the details of the health insurance benefits provided under the employer's plan. It is a crucial document that informs employees about what is covered, any limitations or exclusions, and the rights and responsibilities of the policyholder. The certificate typically includes specifics such as coverage amounts, deductibles, copayments, and premium costs, helping employees understand their insurance plan effectively. It is distinct from other documents; for instance, a policy is usually a more comprehensive document describing the entire insurance agreement between the insurer and the employer rather than individual employees. An enrollment form is used for initial sign-up, while an insurance card provides basic identification and access to services but does not detail coverage in the same comprehensive manner as a certificate. Thus, the certificate is the correct answer, as it directly addresses the need to inform each employee about their specific health coverage under the employer's health plan.

**9. What type of policy would most likely include a provision for tail coverage?**

- A. Whole life insurance**
- B. Term life insurance**
- C. Claims-made malpractice insurance**
- D. Universal health insurance**

The type of policy that would most likely include a provision for tail coverage is claims-made malpractice insurance. Tail coverage is specifically designed for claims-made policies, which provide coverage for claims that are made during a specific period, typically while the policyholder is actively insured. Once a claims-made policy is terminated, any claims that arise from incidents that occurred during the policy period but are reported afterward would not be covered unless tail coverage is purchased. Tail coverage serves as an extension that allows the insured professional to remain protected against claims made after the policy has expired for incidents that occurred while the policy was active. This is critical for professionals in fields such as medicine or law, where the risk of future claims can remain long after the services were rendered. In contrast, whole life insurance and term life insurance generally do not involve the same principles as claims-made policies, as they do not cover liability claims arising from professional services. Universal health insurance focuses more on providing health coverage rather than liability protection and does not include provisions related to professional liability or the need for tail coverage.

**10. Who is referred to as a "beneficiary" in a health insurance policy?**

- A. The policyholder who pays for coverage**
- B. An individual designated to receive policy benefits**
- C. The insurance agent selling the policy**
- D. The healthcare provider giving the medical services**

In the context of a health insurance policy, a "beneficiary" is specifically the individual designated to receive benefits from the policy upon the occurrence of a covered event, such as a serious illness or injury. The role of the beneficiary is crucial because they are the ones who will be compensated for claims made against the policy, typically in the case of life insurance. However, in health insurance, while the policyholder may benefit from the coverage they paid for, and providers deliver the service, it is the beneficiary who receives the financial support to help mitigate medical costs. This distinction is vital: while policyholders pay for their coverage to protect themselves against health expenses, and the healthcare providers deliver necessary medical services, it is the beneficiary who is identified by the terms of the policy to receive benefits in defined circumstances, such as death or other specified conditions that trigger benefits. This understanding reinforces the centrality of the beneficiary's role in the overarching structure of health and accident insurance.

# 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://healthaccidentinsurance.examzify.com>**

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

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