

LIFE & HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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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 year did the Supreme Court intervene regarding the Federal Trade Commission's authority over insurance?**
 - A. 1944
 - B. 1958
 - C. 1959
 - D. 1868
- 2. How does a pre-existing condition exclusion affect an individual considering a new insurance contract?**
 - A. It may allow full coverage without limitations
 - B. It might increase the premium cost
 - C. It may reduce her benefits
 - D. It has no impact on the new policy
- 3. What term refers to a condition that increases the likelihood of a loss occurring?**
 - A. Risk
 - B. Exposure
 - C. Hazard
 - D. Liability
- 4. Who funds the insurance program provided by government insurers?**
 - A. Private investors
 - B. The populace through taxation
 - C. Insurance premiums
 - D. State grants
- 5. Which department within an insurance company is responsible for reviewing and approving applications?**
 - A. Claims Department
 - B. Underwriting Department
 - C. Risk Management Department
 - D. Reinsurance Department

- 6. What is typically meant by "Any Occupation" in a disability policy?**
- A. Inability to perform one's own job
 - B. Inability to perform any job for which one is trained
 - C. Ability to perform any job
 - D. Temporary disability only
- 7. What is a characteristic of a voidable contract?**
- A. It cannot be canceled under any circumstances
 - B. It may be set aside by one party for a satisfactory reason
 - C. It requires consent from both parties to be effective
 - D. It is not legally enforceable
- 8. What type of organization provides insurance to its members but is also classified as a nonprofit?**
- A. Commercial Insurance Company
 - B. Fraternal Benefit Society
 - C. Reciprocal Exchange
 - D. Mutual Insurance Company
- 9. What type of care provides daily nursing care that can only be provided by medical personnel?**
- A. Custodial care
 - B. Respite care
 - C. Intermediate care
 - D. Skilled care
- 10. What is the definition of loss exposure?**
- A. The risk of a possible gain
 - B. The risk of a possible loss
 - C. The identification of insured items
 - D. The condition of insurance contracts

Answers

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

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Explanations

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1. Which year did the Supreme Court intervene regarding the Federal Trade Commission's authority over insurance?

- A. 1944
- B. 1958**
- C. 1959
- D. 1868

*The correct year when the Supreme Court intervened regarding the Federal Trade Commission's authority over insurance is 1944. This intervention is rooted in the landmark case *United States v. South-Eastern Underwriters Association*, which was decided in that year. This case was significant because it determined that insurance was interstate commerce and thus subject to federal regulation under the Commerce Clause. Prior to this ruling, insurance was primarily regulated by state law, leading to the establishment of a dual regulatory system. While 1958 and 1959 were years that saw various developments in insurance regulation and related legal cases, they did not involve a direct Supreme Court ruling on the FTC's authority over insurance. The year 1868 is not relevant in this context since it predates significant changes in insurance regulation that later occurred in the mid-20th century. Therefore, understanding the impact of the Supreme Court's 1944 decision is crucial in grasping the evolution of insurance regulation and the balance between state and federal authority over this industry.*

2. How does a pre-existing condition exclusion affect an individual considering a new insurance contract?

- A. It may allow full coverage without limitations
- B. It might increase the premium cost
- C. It may reduce her benefits**
- D. It has no impact on the new policy

A pre-existing condition exclusion can significantly impact an individual's new insurance contract, primarily by potentially reducing her benefits. When an insurance company includes a pre-existing condition exclusion, it means that any health condition that existed before the start of the new policy may not be covered or may have limited coverage. This exclusion is put in place to mitigate risk by ensuring that insurers are not liable for conditions that they were not initially underwriting when the policy was issued. For instance, if an individual has a chronic illness prior to obtaining the new insurance, treatment related to that illness may not be covered by the new policy. This means that any medical expenses incurred due to that pre-existing condition would have to be paid out-of-pocket by the insured, reducing the overall benefit available under the policy. While it's important to consider other aspects, such as potential increases in premium costs due to underwriting decisions related to health history, the direct consequence of a pre-existing condition exclusion is a limitation on the benefits associated with the policy for that specific condition. Thus, understanding how these exclusions function is vital for anyone considering a new insurance contract and their overall financial and health planning.

3. What term refers to a condition that increases the likelihood of a loss occurring?

- A. Risk
- B. Exposure
- C. Hazard**
- D. Liability

The term that refers to a condition that increases the likelihood of a loss occurring is "hazard." In the context of insurance, a hazard is something that increases the probability of a peril occurring, which could lead to a loss. Hazards can be classified into various types, including physical hazards (related to the physical condition of property), moral hazards (related to an individual's character or behavior that may affect their actions regarding risk), and legal hazards (arising from regulatory or legal environments). Understanding hazards is crucial in risk assessment and underwriting processes in insurance. For instance, if a property has multiple fire hazards, this may lead insurers to view it as more risky, thus potentially increasing premiums or limiting coverage. Other terms such as risk, exposure, and liability have distinct definitions in the insurance context. Risk broadly refers to the chance of loss occurring. Exposure generally pertains to the state of being subject to loss, while liability pertains to the legal responsibility for damages or injury, which is different from the concept of a hazard. Thus, "hazard" is the most appropriate term for describing a condition that increases the likelihood of loss.

4. Who funds the insurance program provided by government insurers?

- A. Private investors
- B. The populace through taxation**
- C. Insurance premiums
- D. State grants

Government insurance programs are primarily funded by the populace through taxation. This means that the funds collected are derived from taxes levied on individuals and businesses, which are then allocated to support various government-funded insurance initiatives, such as Medicare, Medicaid, unemployment insurance, and workers' compensation programs. This funding model ensures that the insurance programs can provide coverage and services to citizens without the necessity of relying solely on premium payments or private investments, which are more typical in private insurance markets. By using tax revenues, government insurers can offer coverage to a broader segment of the population, including those who may not be able to afford insurance premiums. In contrast, options like private investors, insurance premiums, and state grants do not accurately represent the primary funding mechanism for government insurance programs, as they involve different sources and methods of financing not primarily tied to public taxation.

5. Which department within an insurance company is responsible for reviewing and approving applications?

- A. Claims Department
- B. Underwriting Department**
- C. Risk Management Department
- D. Reinsurance Department

The Underwriting Department is responsible for reviewing and approving applications within an insurance company. This department evaluates the risks associated with insuring a particular individual or entity and determines whether to accept or deny the application based on various factors, such as the applicant's health history, lifestyle, and other relevant data. Underwriters analyze this information to set appropriate premiums and ensure that the company maintains profitability while also providing coverage. The Claims Department, by contrast, focuses on processing and settling claims made by policyholders after an insured event occurs, which is a different function from application approval. The Risk Management Department identifies and mitigates risks the company may face, but it does not typically handle direct applications for insurance. The Reinsurance Department works with other insurers to manage risks and potential losses through reinsurance agreements, rather than managing the application process for individual policies. Thus, the Underwriting Department is the specific area dedicated to assessing applications for coverage.

6. What is typically meant by "Any Occupation" in a disability policy?

- A. Inability to perform one's own job
- B. Inability to perform any job for which one is trained**
- C. Ability to perform any job
- D. Temporary disability only

In the context of a disability policy, "Any Occupation" refers to the inability to perform any job for which the insured is reasonably trained, qualified, or capable of performing. This definition imposes a higher standard of disability compared to more lenient definitions, such as "own occupation," which would only consider the inability to perform one's specific job duties in their current profession. Choosing "Any Occupation" means that for a claim to be validated, the insured must demonstrate that they cannot work in any capacity in the labor market, given their skills, education, and work experience. This standard is often used in long-term disability policies, emphasizing the broader implications of a person's ability to work rather than limiting it to their previous or current job role. This distinction matters as it affects the eligibility for benefits and the payout period. It encourages a thorough examination of the individual's overall capacity to participate in workforce activities, not just a single occupation.

7. What is a characteristic of a voidable contract?

- A. It cannot be canceled under any circumstances
- B. It may be set aside by one party for a satisfactory reason**
- C. It requires consent from both parties to be effective
- D. It is not legally enforceable

A voidable contract is defined as a contract that remains valid and enforceable until one of the parties takes action to void it. This can happen for various reasons, such as misrepresentation, undue influence, duress, or lack of capacity. The key aspect of a voidable contract is that one party has the option to affirm or reject the agreement based on their circumstances or rationale. This inherent feature of a voidable contract allows for the possibility of cancellation by one party if they present satisfactory grounds. This could mean that the affected party may choose to cancel the contract if they feel wronged or misled, thus highlighting the flexibility and protection provided to one party in such scenarios. The other characteristics mentioned in the options do not accurately reflect the nature of a voidable contract. For instance, stating that it cannot be canceled under any circumstances oversimplifies and misrepresents what makes a contract voidable. The requirement of consent from both parties is more aligned with valid contracts rather than voidable ones. Lastly, asserting that a voidable contract is not legally enforceable overlooks that, unless voided, it retains its enforceability.

8. What type of organization provides insurance to its members but is also classified as a nonprofit?

- A. Commercial Insurance Company
- B. Fraternal Benefit Society**
- C. Reciprocal Exchange
- D. Mutual Insurance Company

A fraternal benefit society is a type of organization that provides insurance benefits to its members. These societies are typically organized on a nonprofit basis and operate for the mutual benefit of their members rather than seeking to generate profit. Members usually share a common bond, such as religion, national origin, or membership in a specific organization. Fraternal benefit societies offer life insurance and other types of benefits, and they often engage in social and charitable activities within their communities. This nonprofit status distinguishes them from commercial insurance companies, which are operated for profit, and from mutual insurance companies, which may distribute profits to policyholders but are not specifically categorized as fraternal organizations. By offering support and benefits in a nonprofit framework, fraternal benefit societies align their practices with the cooperative spirit, ensuring that the focus remains on serving members' needs rather than maximizing earnings.

9. What type of care provides daily nursing care that can only be provided by medical personnel?

- A. Custodial care
- B. Respite care
- C. Intermediate care
- D. Skilled care**

Skilled care refers to the type of medical care that requires the expertise of licensed healthcare professionals, such as registered nurses or licensed practical nurses. This level of care is often necessary for individuals who have complex medical needs or require ongoing medical treatments and monitoring. Skilled care typically includes services such as wound care, intravenous therapy, medication management, and other forms of monitoring and treatment that are beyond the capabilities of non-medical personnel. Understanding this concept is crucial as it distinguishes skilled care from other types of care that may not require licensed personnel. For instance, custodial care primarily focuses on assistance with activities of daily living, like bathing or dressing, and does not generally involve medical skill. Respite care provides temporary relief for individuals caring for those with illnesses or disabilities, but it isn't necessarily medical care. Intermediate care may include some level of nursing supervision but is not as intensive as skilled care. The emphasis on the requirement of trained medical personnel in skilled care ensures that patients receive appropriate treatment and support for their health needs, underscoring its importance in the broader context of healthcare services.

10. What is the definition of loss exposure?

- A. The risk of a possible gain
- B. The risk of a possible loss**
- C. The identification of insured items
- D. The condition of insurance contracts

Loss exposure refers specifically to the potential for financial loss associated with various risks that an individual or organization may face. It encompasses scenarios where there is a likelihood that certain events could occur, leading to a depletion of assets or income. In the context of insurance, identifying loss exposures is crucial because it helps determine what aspects need coverage to mitigate potential financial consequences. The notion of loss exposure is foundational in risk management. Organizations and insurance providers analyze these exposures to develop strategies that may include risk avoidance, risk reduction, risk sharing, or transferring the risk through insurance. The other concepts presented do not align with the standard understanding of loss exposure. The first option conceptually introduces a scenario that is not relevant to insurance since focusing on potential gains does not pertain to the risks typically covered by insurance policies. The identification of insured items is more about asset management. Lastly, the condition of insurance contracts speaks to the legal and functional aspects of insurance agreements rather than the underlying risks associated with loss exposures.

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://lifeandhealthinsurance.examzify.com>

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

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