

LLQP Accident and Sickness Insurance Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Questions

- 1. What financial aspect must be satisfied for the FPO Rider to be applied?**
 - A. Age restrictions must be met**
 - B. Medically underwritten confirmation**
 - C. Financial underwriting must be completed**
 - D. Additional spouse insurance must be acquired**
- 2. Which document typically summarizes the essential details of an insurance policy?**
 - A. The policy declaration page**
 - B. The underwriting report**
 - C. The claims settlement document**
 - D. The beneficiary designation form**
- 3. What does 'renewability' refer to in insurance policies?**
 - A. The possibility of changing insurance providers**
 - B. The frequency of premium payments**
 - C. The terms under which a policy can be renewed**
 - D. The option to expand coverage later**
- 4. What type of risk affects a specific business rather than the market as a whole?**
 - A. Systematic risk**
 - B. Non-systematic risk**
 - C. Morbidity**
 - D. Mortality**
- 5. What is the effect of exclusions in a health insurance policy?**
 - A. They increase the scope of covered services**
 - B. They clarify what is included in a wellness program**
 - C. They limit coverage for certain pre-existing conditions**
 - D. They enhance the policy by adding optional benefits**

- 6. Allowable expenses in health insurance refer to what?**
- A. Costs that are never covered**
 - B. Costs that are eligible for coverage under a policy**
 - C. Expenses related to insurance administration**
 - D. Premiums paid to maintain the insurance**
- 7. What percentage does long term disability insurance typically pay?**
- A. 70-75%**
 - B. 50-60%**
 - C. 80-85%**
 - D. 40-45%**
- 8. What are the two qualifications required for a CPP disability benefit?**
- A. Severe and temporary**
 - B. Severe and prolonged**
 - C. Permanent and less severe**
 - D. Temporary and habitual**
- 9. Are premiums for Business Loan Protection Insurance tax deductible?**
- A. Yes**
 - B. No**
 - C. Only for small businesses**
 - D. Depends on the loan amount**
- 10. What is a potential downside of short-term health insurance?**
- A. It covers all medical expenses, regardless of duration**
 - B. It may not provide comprehensive coverage for ongoing healthcare needs**
 - C. It is only available to those under the age of 25**
 - D. It has no waiting period for coverage to begin**

Answers

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

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Explanations

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1. What financial aspect must be satisfied for the FPO Rider to be applied?

- A. Age restrictions must be met**
- B. Medically underwritten confirmation**
- C. Financial underwriting must be completed**
- D. Additional spouse insurance must be acquired**

The FPO Rider, which stands for Future Purchase Option Rider, is a provision that allows policyholders to increase their coverage without undergoing additional medical underwriting at specified intervals. This flexibility is valuable because it enables insured individuals to adjust their policies in response to life changes, such as a higher income or family expansion. For the FPO Rider to be applied, it is critical that financial underwriting is completed. This step ensures that the insurer evaluates the policyholder's financial situation, determining their ability to support higher coverage levels. The underlying principle is to prevent over-insurance relative to the insured's actual financial needs and capacities. By assessing financial underwriting, insurers can adequately offer the rider while maintaining responsible risk management and ensuring that the insured can afford the additional coverage. Other aspects, such as age restrictions, medically underwritten confirmation, and acquiring additional spouse insurance, may influence coverage options but are not direct prerequisites for activating the FPO Rider. Therefore, the completion of financial underwriting stands out as the essential criterion to apply the FPO Rider.

2. Which document typically summarizes the essential details of an insurance policy?

- A. The policy declaration page**
- B. The underwriting report**
- C. The claims settlement document**
- D. The beneficiary designation form**

The policy declaration page serves as a crucial component of an insurance policy as it succinctly summarizes the essential details. This document typically includes important information such as the name of the insured, the type of coverage provided, the policy number, the coverage limits, and the policy term. It acts as a quick reference guide that allows both the insurer and the insured to understand the fundamental aspects of the policy at a glance. While other documents mentioned in the choices serve specific functions, they do not summarize policy details in the same way. The underwriting report focuses on the assessment of risks and underwriting decisions made by the insurer, which is more technical and detailed. The claims settlement document relates to the details of how a claim is processed and settled, providing information relevant mainly after a loss occurs. On the other hand, the beneficiary designation form is used to specify who will receive benefits upon the insured event, rather than summarizing the overall terms of coverage. Therefore, the policy declaration page is the document that best encapsulates the critical information about an insurance policy.

3. What does 'renewability' refer to in insurance policies?

- A. The possibility of changing insurance providers
- B. The frequency of premium payments
- C. The terms under which a policy can be renewed**
- D. The option to expand coverage later

Renewability in insurance policies specifically refers to the terms under which a policy can be renewed. This concept is crucial for policyholders to understand, as it dictates the conditions and rights associated with continuing coverage once the initial term of the policy expires. When a policy includes a renewal clause, it typically outlines the duration of coverage, the process for renewing the policy, any changes in premium or coverage terms, and whether the insurer can deny renewal based on the insured's claims history or other underwriting criteria. Having a clear understanding of renewability helps insurance buyers ensure they have continuous protection without facing unexpected cancellations or changes in coverage conditions as they reach the end of their policy term. This contrasts with concepts like changing providers, payment frequency, or expanding coverage, which do not directly address the continuity of the policy in its current form.

4. What type of risk affects a specific business rather than the market as a whole?

- A. Systematic risk
- B. Non-systematic risk**
- C. Morbidity
- D. Mortality

Non-systematic risk, also known as specific risk or idiosyncratic risk, refers to the risk that is unique to a particular company or industry. This type of risk can arise from factors such as management decisions, product recalls, or regulatory changes that specifically impact a single business or sector. Since non-systematic risk is not correlated with market risks, it can be reduced through diversification in a portfolio; by holding a variety of investments, the impact of a negative event affecting one specific investment can be mitigated by others that are performing well. In contrast, systematic risk affects the entire market or a large segment of it, such as changes in economic policy, interest rates, or natural disasters that can impact all businesses in a significant way. Morbidity and mortality are terms used primarily in the context of health and life insurance, representing health-related risk (morbidity) and death-related risk (mortality), but they do not specifically describe risks that affect particular businesses. Understanding the distinction between these types of risks is essential for effective risk management and investment strategies, particularly when assessing the potential volatility and specific risks associated with individual investments.

5. What is the effect of exclusions in a health insurance policy?

- A. They increase the scope of covered services**
- B. They clarify what is included in a wellness program**
- C. They limit coverage for certain pre-existing conditions**
- D. They enhance the policy by adding optional benefits**

Exclusions in a health insurance policy serve to limit coverage for specific situations or conditions. This means that particular pre-existing conditions or specific events may not be covered under the policy, thus shifting the risk back to the policyholder for those items. By clearly delineating what is not covered, exclusions help insurance providers manage their risk and allow policyholders to understand the limitations of their coverage. For instance, if a health insurance policy includes an exclusion for pre-existing conditions, it might specifically state that any medical issues that existed prior to the policy's effective date won't be covered, regardless of when they arise. This clarity around exclusions is crucial for both the insurer and the insured, ensuring that there is a mutual understanding of what will and won't be compensated for. In contrast, increasing the scope of covered services, clarifying what is included in a wellness program, or enhancing the policy by adding optional benefits does not pertain to exclusions. These aspects instead focus on broadening coverage rather than limiting it, which is the primary role of exclusions within a health insurance context.

6. Allowable expenses in health insurance refer to what?

- A. Costs that are never covered**
- B. Costs that are eligible for coverage under a policy**
- C. Expenses related to insurance administration**
- D. Premiums paid to maintain the insurance**

Allowable expenses in health insurance are defined as costs that are eligible for coverage under a policy. These expenses are typically specified within the policy documents and may include a variety of medical services, treatments, and procedures that the insurance plan covers. The importance of understanding allowable expenses lies in knowing what costs can be reimbursed by the insurer, aiding policyholders in maximizing their benefits and minimizing out-of-pocket expenses. Allowable expenses are part of the insurance agreement, ensuring that the insured knows which healthcare costs will be supported by their insurance, thus providing clarity and helping them navigate their healthcare needs.

7. What percentage does long term disability insurance typically pay?

- A. 70-75%
- B. 50-60%**
- C. 80-85%
- D. 40-45%

Long-term disability insurance typically pays a percentage of an individual's pre-disability earnings, and the common range for these benefits is between 60% and 70% of the employee's gross income prior to the onset of the disability. The correct range stated in the options indicates that long-term disability insurance generally offers benefits that replace a significant portion of lost income due to an inability to work because of illness or injury. While responses indicating lower percentages like 50-60%, or even higher percentages like 80-85% and 40-45% may seem plausible, they do not align with standard industry practices. Insurers design these policies to amount to enough total income replacement to support individuals during long-term disabilities without providing overly generous payouts that might discourage returning to work after recovery. Hence, the range commonly accepted in the industry reflects a balance of providing sufficient financial support while encouraging individuals to eventually transition back to work.

8. What are the two qualifications required for a CPP disability benefit?

- A. Severe and temporary
- B. Severe and prolonged**
- C. Permanent and less severe
- D. Temporary and habitual

The correct answer is "severe and prolonged." The Canada Pension Plan (CPP) disability benefit is designed to provide financial support to individuals who are unable to work due to a disability. For a claimant to qualify for these benefits, their condition must meet two specific criteria: it must be severe and prolonged. "Severe" means that the disability significantly impairs the individual's ability to perform any type of work. This requirement ensures that only those who truly cannot maintain gainful employment due to health reasons can access these benefits. "Prolonged" refers to the expectation that the disability is long-term, lasting for an extended period or is likely to do so. This underscores that the CPP disability benefit is not intended for temporary conditions that may resolve relatively quickly. Instead, the program is aimed at assisting individuals who are facing long-lasting disabilities that hinder their capacity to work for the foreseeable future. In contrast, the other options present qualifications that do not align with the criteria for CPP benefits. For example, "temporary" implies a short duration, which contradicts the program's intent to support those with enduring disabilities. The phrases "less severe" and "habitual" also fail to capture the seriousness and longevity of conditions necessary to qualify for benefits under the CPP.

9. Are premiums for Business Loan Protection Insurance tax deductible?

- A. Yes**
- B. No**
- C. Only for small businesses**
- D. Depends on the loan amount**

Premiums for Business Loan Protection Insurance are not tax deductible. This type of insurance is designed to cover loan repayments in the event of the borrower's death or disability, thereby providing financial stability to the business. Since the premiums are considered a personal expense, they do not qualify for tax deductions like other business-related expenses, such as operational costs or equipment purchases. Understanding why premiums are not tax deductible involves recognizing the nature of business-related insurance. While certain insurance products that protect against business losses may be deductible, personal insurance policies or those tied closely to an individual's health status do not fall under this category for tax purposes. Thus, the correct assessment is that these premiums are indeed not tax deductible.

10. What is a potential downside of short-term health insurance?

- A. It covers all medical expenses, regardless of duration**
- B. It may not provide comprehensive coverage for ongoing healthcare needs**
- C. It is only available to those under the age of 25**
- D. It has no waiting period for coverage to begin**

Short-term health insurance is designed to provide temporary coverage for individuals who are in transitional phases, such as between jobs or waiting for other insurance to kick in. One of the main characteristics of short-term health insurance is that it often does not offer comprehensive coverage for ongoing healthcare needs. This means that while it might cover some immediate or specific medical expenses, it may not include essential benefits like preventive care, mental health services, or treatment for chronic conditions. As a result, individuals who rely solely on short-term health insurance may find themselves at risk of high out-of-pocket costs if they require ongoing treatment or have health issues that extend beyond the coverage period. It is essential for consumers to understand this limitation so they can adequately plan for their healthcare needs, especially if they anticipate requiring sustained medical services.