

Louisiana Life and Health Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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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

- 1. What is the effective period for a temporary producer's license?**
 - A. 90 days**
 - B. 120 days**
 - C. 180 days**
 - D. 365 days**
- 2. A nonprofit health service plan may NOT issue a contract that covers which of the following types of benefits?**
 - A. Disability income benefits**
 - B. Hospitalization benefits**
 - C. Outpatient care benefits**
 - D. Preventive care benefits**
- 3. According to COBRA, what must be true regarding a terminated employee's benefits?**
 - A. They can be reduced significantly**
 - B. They must be the same with the premium not exceeding 102%**
 - C. They are only valid for three months**
 - D. They can be discontinued at any time**
- 4. Under the Fair Credit Reporting Act, which statement is true?**
 - A. The consumer who was investigated must be advised if insurance was denied**
 - B. The consumer must give consent for their report to be shared**
 - C. The consumer cannot dispute information on their credit report**
 - D. The consumer must be informed if an unfavorable report was used for employment**
- 5. A long-term care policy typically provides which of the following levels of care EXCEPT?**
 - A. Home health care**
 - B. Skilled nursing care**
 - C. Acute care**
 - D. Assisted living care**

- 6. What does a Medicare Supplement Policy aim to do?**
- A. Eliminate all Medicare costs**
 - B. Fill in the gaps of Part A and Part B Medicare**
 - C. Provide long-term care coverage**
 - D. Offer discounts on prescription drugs**
- 7. Which of the following best describes a mutual insurer?**
- A. An entity owned by policyholders**
 - B. An entity owned by stockholders**
 - C. An entity providing only life insurance**
 - D. An entity offering only health insurance**
- 8. What must an applicant sign when a life insurance policy is replaced?**
- A. Notice regarding the premium assessment**
 - B. Notice regarding replacement of life insurance**
 - C. Notice regarding policy amendment**
 - D. Notice regarding beneficiary designation**
- 9. Fixed period settlement options are classified as a form of which financial product?**
- A. Life insurance**
 - B. Annuity**
 - C. Health insurance**
 - D. Disability insurance**
- 10. In a health plan, what is the term for the list that details the amounts payable for specified injuries or procedures?**
- A. Policy outline**
 - B. Exclusion list**
 - C. Benefit schedule**
 - D. Coverage outline**

Answers

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

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Explanations

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1. What is the effective period for a temporary producer's license?

- A. 90 days**
- B. 120 days**
- C. 180 days**
- D. 365 days**

A temporary producer's license in Louisiana is issued to allow an individual to engage in insurance activities while they are awaiting the issuance of their permanent license. This type of license is valid for a specific effective period to ensure that the individual is not left unlicensed for an extended duration. In Louisiana, the effective period for a temporary producer's license is indeed 180 days. This duration allows the individual enough time to complete the licensing process while still being active in the field. Other durations listed, such as 90 days, 120 days, and 365 days, do not align with the regulations set forth by Louisiana state law regarding temporary licenses. Therefore, the 180 days is specifically designed to balance the need for immediate engagement in insurance activities with the requirement for thorough training and assessment before receiving a standard license. This understanding of temporary licenses is essential for anyone studying insurance laws in Louisiana.

2. A nonprofit health service plan may NOT issue a contract that covers which of the following types of benefits?

- A. Disability income benefits**
- B. Hospitalization benefits**
- C. Outpatient care benefits**
- D. Preventive care benefits**

A nonprofit health service plan is typically designed to provide specific health-related benefits and often focuses on managing healthcare delivery rather than providing cash benefits. Disability income benefits are financial benefits provided when an individual is unable to work due to a health issue, which falls outside the traditional scope of health services provided by a nonprofit health service plan. Instead, nonprofit health service plans are generally structured to cover services like hospitalization, outpatient care, and preventive care, which are direct healthcare services aimed at improving the health and well-being of individuals. These plans focus on connectivity to health providers and ensuring access to medically necessary services rather than on financial compensation for lost wages due to disability. Thus, the correct choice reflects the limits of nonprofit health service plans in relation to the benefits they are authorized to provide.

3. According to COBRA, what must be true regarding a terminated employee's benefits?
- A. They can be reduced significantly
 - B. They must be the same with the premium not exceeding 102%**
 - C. They are only valid for three months
 - D. They can be discontinued at any time

Under COBRA (Consolidated Omnibus Budget Reconciliation Act), terminated employees are entitled to continue their group health insurance benefits for a limited time after losing their job or experiencing a reduction in hours. The key point of this regulation is that the benefits provided under COBRA must be the same as those that the employee was receiving while employed. This ensures that the terminated employee does not lose access to the same level of care and coverage they previously had. Furthermore, the premiums for COBRA coverage cannot exceed 102% of the cost of the plan for active employees, which includes the employer's contribution and an additional 2% to cover administrative costs. This provision allows for continuity of care without imposing a significant financial burden on the employee, making them responsible for the full premium plus a small administrative fee. The other options do not align with the provisions laid out by COBRA. Benefits cannot be reduced significantly, they cannot be limited to only three months, and they cannot be discontinued at any time in a way that undermines the rights granted by COBRA. This framework is designed to protect employees during transitions and ensure they have access to necessary health coverage.

4. Under the Fair Credit Reporting Act, which statement is true?
- A. The consumer who was investigated must be advised if insurance was denied**
 - B. The consumer must give consent for their report to be shared
 - C. The consumer cannot dispute information on their credit report
 - D. The consumer must be informed if an unfavorable report was used for employment

The Fair Credit Reporting Act (FCRA) is designed to protect consumer information in reporting and ensures that individuals can manage the accuracy of their credit reports. Among the provisions of this act, individuals must be informed if they are adversely affected by information contained in a credit report. When an insurance application is denied based on information obtained from a consumer reporting agency, it is required that the consumer be notified of this denial. This is to ensure that consumers are aware of the information that has affected their insurance eligibility and provides them with the opportunity to review that information. Notification allows consumers to request further details about the report used and to take action if they find any inaccuracies. By requiring that consumers be advised if their insurance has been denied due to information from a credit report, the FCRA supports transparency and fairness in credit reporting practices.

5. A long-term care policy typically provides which of the following levels of care EXCEPT?

- A. Home health care**
- B. Skilled nursing care**
- C. Acute care**
- D. Assisted living care**

Long-term care policies are designed to assist individuals who require care over an extended period, often due to chronic illnesses or disabilities. These policies typically cover several types of care options, including home health care, skilled nursing care, and assisted living care. Home health care refers to the support services provided in a person's home, which can include medical assistance, personal care, and therapeutic services. Skilled nursing care includes services provided by licensed nurses in settings such as nursing homes or rehabilitation facilities, focusing on medical needs that can't be managed solely by caregivers. Assisted living care offers a combination of housing, personalized support services, and healthcare to help individuals who need assistance with daily activities but do not require full medical care. Acute care, however, is generally associated with immediate and short-term treatment for severe medical conditions that typically require hospitalization, such as surgeries or emergencies. Long-term care policies do not include provisions for acute care because the focus is on ongoing support for daily living activities rather than intensive medical treatment. Thus, this distinction is what makes acute care the correct choice as not being covered by a long-term care policy.

6. What does a Medicare Supplement Policy aim to do?

- A. Eliminate all Medicare costs**
- B. Fill in the gaps of Part A and Part B Medicare**
- C. Provide long-term care coverage**
- D. Offer discounts on prescription drugs**

A Medicare Supplement Policy, also known as Medigap, is specifically designed to fill in the gaps of coverage left by Medicare Parts A and B. While Medicare provides substantial health coverage for seniors, it does not cover all healthcare costs. For example, Medicare has deductibles, coinsurance, and copayments, which can lead to significant out-of-pocket expenses for beneficiaries. The purpose of a Medicare Supplement Policy is to cover these additional costs, thus helping to reduce the financial burden of healthcare for individuals who rely on Medicare. These policies can help pay for things like hospital stays that Medicare does not fully cover, or the coinsurance for outpatient services. The other choices do not accurately reflect the purpose of a Medicare Supplement Policy. Eliminating all Medicare costs is beyond the intent of Medigap since it only supplements existing Medicare coverage rather than completely covering all costs. Providing long-term care coverage is a different kind of insurance product, and discounts on prescription drugs are part of the Medicare Part D benefits, not Medigap. Thus, the focus of a Medicare Supplement Policy remains on complementing the coverage provided by Medicare, which makes the chosen answer the most accurate.

7. Which of the following best describes a mutual insurer?

- A. An entity owned by policyholders**
- B. An entity owned by stockholders**
- C. An entity providing only life insurance**
- D. An entity offering only health insurance**

A mutual insurer is best described as an entity owned by policyholders. This structure means that the policyholders are both the customers of the insurance service and the owners of the company. They participate in the profitability of the insurer, often receiving dividends or other benefits based on the company's performance. In contrast to stock insurers, which are owned by shareholders who may not have any direct association with the insurance products, mutual insurers focus on serving their policyholders' interests rather than maximizing shareholder profits. The other options mention ownership structures or specific types of insurance. While stock insurers are owned by shareholders, that does not apply to mutual insurers. Likewise, limiting the scope to only life or health insurance does not accurately reflect the broader nature of mutual insurers, as they can provide various types of insurance products beyond just life or health coverage.

8. What must an applicant sign when a life insurance policy is replaced?

- A. Notice regarding the premium assessment**
- B. Notice regarding replacement of life insurance**
- C. Notice regarding policy amendment**
- D. Notice regarding beneficiary designation**

When a life insurance policy is replaced, the applicant is required to sign a Notice regarding replacement of life insurance. This notice serves several important purposes. It informs the applicant about the implications of replacing an existing policy with a new one, including potential loss of benefits, changes in premiums, and the possibility of lapsing the old policy, which could affect coverage. The notice is designed to protect consumers by ensuring they are fully aware of the consequences of their decision to replace an insurance policy. It emphasizes the importance of understanding the features and benefits of both the existing policy and the new policy being considered. This practice is in line with regulations that aim to promote informed decision-making among policyholders. Other options such as notices regarding premium assessment, policy amendments, or beneficiary designations do not specifically address the act of replacing a life insurance policy and therefore are not required in this context.

9. Fixed period settlement options are classified as a form of which financial product?

- A. Life insurance**
- B. Annuity**
- C. Health insurance**
- D. Disability insurance**

Fixed period settlement options are indeed classified as a form of annuity. This classification is based on how these options function within financial products. In an annuity, the individual invests a lump sum or makes a series of payments to receive regular income payments at a later time. When a fixed period settlement option is selected, the insurer pays out a specified amount of money over a predetermined period, which is characteristic of how annuities operate. The goal is to provide financial security and a predictable income stream for the duration of the selected period. This method of distribution combines the elements of time and financial planning found in annuities. In contrast, life insurance, health insurance, and disability insurance primarily focus on providing financial protection or benefits related to death, health issues, or inability to work due to disability, rather than structured income payments over time. Therefore, while they serve essential roles in financial planning, they do not encompass the characteristics that define fixed period settlement options as annuities do.

10. In a health plan, what is the term for the list that details the amounts payable for specified injuries or procedures?

- A. Policy outline**
- B. Exclusion list**
- C. Benefit schedule**
- D. Coverage outline**

The appropriate term for the list that specifies the amounts payable for designated injuries or procedures in a health plan is referred to as the "benefit schedule." This schedule is integral to understanding what costs the health plan will cover and to what extent. It typically outlines various medical services, procedures, or treatments along with the corresponding reimbursements or payment amounts. Having a benefit schedule allows policyholders to anticipate their out-of-pocket expenses based on the services they might require, as it provides a clear framework for what the insurance intends to pay. The other options presented do not accurately describe this specific list. A policy outline generally provides a summary of the policy's key features but does not specify payment amounts for services. An exclusion list details what is not covered by the policy, rather than what is covered and the amounts payable. A coverage outline might summarize the areas in which coverage applies but lacks the detailed payment information found in a benefit schedule.

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://louisiana-lifeandhealth.examzify.com>

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