

NORTH CAROLINA ACCIDENT AND HEALTH 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. In a Disability Income policy, which of these clauses acts as a deductible?**
 - A. Residual Benefit clause
 - B. Elimination Period
 - C. Waiting Period
 - D. Termination Clause
- 2. What action can the Commissioner of insurance take if a licensed person is found to have engaged in fraudulent or dishonest practices?**
 - A. Issue a warning
 - B. Suspend, revoke, or refuse to renew the agent's license
 - C. Fines or penalties
 - D. Provide additional training
- 3. Which aspect of managed care plans helps control medical costs?**
 - A. Allowing unlimited provider choices without restrictions
 - B. Contracting with a network of healthcare providers
 - C. Setting fixed premium amounts regardless of patient usage
 - D. Covering all medical procedures without limitations
- 4. What does "out-of-pocket maximum" refer to in health insurance?**
 - A. The total health care costs after which the insurer pays 100% of expenses
 - B. The fixed annual fee for maintaining insurance coverage
 - C. The deductible amount an insured must pay before coverage starts
 - D. The costs associated with non-covered services
- 5. What is the primary purpose of underwriting in health insurance?**
 - A. To increase premiums
 - B. To assess risk and determine eligibility
 - C. To sell policies
 - D. To deny applicants

- 6. Which document specifies the amount of benefits to be paid in a health policy?**
- A. Exclusions
 - B. Conditions
 - C. Insuring clause
 - D. Renewal clause
- 7. What differentiates an HMO from a PPO?**
- A. An HMO requires members to choose a primary care physician
 - B. A PPO requires referrals for specialists
 - C. An HMO covers more out-of-network services
 - D. A PPO has a lower deductible
- 8. How must an applicant demonstrate knowledge to be licensed in accident and health insurance in North Carolina?**
- A. Pass a set of practice tests
 - B. Complete 20 hours of approved instruction
 - C. Provide prior work experience
 - D. Pass a background check
- 9. What is a "rider" in an insurance policy?**
- A. An addition to a basic policy that modifies its coverage or terms
 - B. A type of insurance policy specifically for high-risk individuals
 - C. A standard procedure in processing health insurance claims
 - D. A legal requirement for insurance companies to disclose risks
- 10. Which statement is true regarding a group accident and health policy issued to an employer?**
- A. The employer keeps the policy while employees receive nothing
 - B. Each employee is issued a direct contract with the insurer
 - C. The employer receives the policy and each employee is issued a certificate
 - D. All employees share a single policy document

Answers

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

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Explanations

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1. In a Disability Income policy, which of these clauses acts as a deductible?

- A. Residual Benefit clause
- B. Elimination Period**
- C. Waiting Period
- D. Termination Clause

The elimination period in a Disability Income policy serves as a crucial time frame after a disability occurs before the benefits begin to be paid. This period is similar to a deductible in that it requires the insured to bear a portion of the financial burden upfront before receiving any payment from the insurance policy. During the elimination period, which may range from a few weeks to several months, the insured must manage their expenses without benefits. This delay incentivizes the policyholder to return to work or explore other recovery options, as they will only start receiving income benefits after successfully navigating this waiting phase. This structure effectively makes the elimination period a financial responsibility the insured must fulfill before gaining access to their benefits, similar to how a deductible requires payment before insurance coverage kicks in. Other options mentioned do not function in the same manner; for example, the residual benefit clause and termination clause relate to claims processing and policy terms but do not stand as a threshold that must be met before benefits begin.

2. What action can the Commissioner of insurance take if a licensed person is found to have engaged in fraudulent or dishonest practices?

- A. Issue a warning
- B. Suspend, revoke, or refuse to renew the agent's license**
- C. Fines or penalties
- D. Provide additional training

The action that can be taken by the Commissioner of Insurance in response to a licensed person found engaging in fraudulent or dishonest practices is to suspend, revoke, or refuse to renew the agent's license. This measure serves as a serious enforcement mechanism designed to protect consumers and maintain integrity within the insurance industry. By removing the license of an agent involved in such practices, the Commissioner ensures that individuals who may harm consumers through deceitful activities are no longer permitted to operate in that capacity. The importance of this action lies in its deterrent effect; it signifies that the insurance profession is held to high ethical standards and that violations will result in significant consequences. This approach helps to uphold public trust in the insurance system, ensuring that only honest and competent professionals are allowed to serve the needs of policyholders. Other potential actions, such as issuing a warning, imposing fines or penalties, or providing additional training, may be part of regulatory measures but do not carry the same weight as license suspension or revocation when it comes to addressing serious misconduct. A warning may not be sufficient for acts of fraud, fines may not prevent future offenses, and additional training does not directly remove the immediate risk posed by a dishonest actor. Thus, the suspension, revocation, or refusal to renew an

3. Which aspect of managed care plans helps control medical costs?

- A. Allowing unlimited provider choices without restrictions
- B. Contracting with a network of healthcare providers**
- C. Setting fixed premium amounts regardless of patient usage
- D. Covering all medical procedures without limitations

Contracting with a network of healthcare providers is a crucial mechanism that managed care plans use to control medical costs. By establishing agreements with a specific group of providers, managed care plans can negotiate lower rates for services. This creates a financial incentive for patients to use in-network providers, which helps to steer patient care toward those who offer the most cost-effective services while maintaining quality. The network model helps to manage costs by limiting the number of providers patients can access without facing higher out-of-pocket expenses, thereby reducing unnecessary and costly services. This, in turn, allows managed care organizations to offer competitive premiums and manage overall healthcare expenditures effectively. The other options suggest approaches that do not effectively manage costs. Allowing unlimited provider choices without restrictions would likely lead to increased costs due to less control over pricing and provider quality. Setting fixed premium amounts regardless of patient usage may seem attractive but does not address the underlying costs associated with healthcare provision. Covering all medical procedures without limitations could lead to overutilization of services, further driving up expenses without necessary oversight.

4. What does "out-of-pocket maximum" refer to in health insurance?

- A. The total health care costs after which the insurer pays 100% of expenses**
- B. The fixed annual fee for maintaining insurance coverage
- C. The deductible amount an insured must pay before coverage starts
- D. The costs associated with non-covered services

The term "out-of-pocket maximum" in health insurance signifies the total amount an insured individual must pay for covered health care services within a specific policy year. Once this limit is reached, the insurance company covers 100% of the costs for additional covered services for the remainder of that year. This provision is designed to protect policyholders from excessive financial burden due to healthcare costs. In contrast, the other options do not accurately describe the out-of-pocket maximum. The fixed annual fee for maintaining insurance coverage refers to premiums, not the out-of-pocket maximum. The deductible is the amount an insured must pay upfront before insurance kicks in, which is not related to the out-of-pocket limit. Costs associated with non-covered services pertain to expenses not reimbursed by insurance at all and are therefore separate from the benefits that come into effect after reaching the out-of-pocket maximum.

5. What is the primary purpose of underwriting in health insurance?

- A. To increase premiums
- B. To assess risk and determine eligibility**
- C. To sell policies
- D. To deny applicants

The primary purpose of underwriting in health insurance is to assess risk and determine eligibility. Underwriting is a crucial process where insurers evaluate the information provided by applicants to decide how much risk the company is willing to accept in insuring an individual. This involves analyzing various factors such as age, medical history, lifestyle choices, and other relevant criteria to gauge the potential costs associated with insuring that person. When underwriters assess risk, they are establishing whether the individual poses a higher chance of requiring significant medical care, which in turn can impact premium rates and the decision to offer coverage. By accurately evaluating risk, insurance companies can ensure that they maintain profitability while still providing coverage to those who need it. This not only protects the insurer but also helps keep premiums manageable for policyholders by distributing risk across a broad pool of insured individuals. In contrast, while increasing premiums, selling policies, or denying applicants are all aspects that might occur in the insurance process, they are not the primary focus of underwriting. Rather, underwriting specifically centers on assessing the risk and determining the eligibility of applicants for coverage.

6. Which document specifies the amount of benefits to be paid in a health policy?

- A. Exclusions
- B. Conditions
- C. Insuring clause**
- D. Renewal clause

The insuring clause is a fundamental component of a health policy that explicitly outlines the benefits that are provided to the insured. It typically details the specific coverage amounts, types of medical services covered, and the conditions under which benefits will be paid. This clause serves as the primary statement of the insurer's commitment to provide financial protection against healthcare costs. In short, the insuring clause is crucial because it defines the scope and limits of the coverage, including how much the insurance company will pay for various medical expenses. Understanding this clause is essential for policyholders, as it determines their financial protection and the resources available to them in case of health events. In contrast, exclusions refer to conditions or circumstances that are not covered by the policy, conditions specify the requirements or situations that must be met for the policy to be valid, and the renewal clause addresses the terms under which the policy can be renewed, but none of these directly specify the amount of benefits to be paid.

7. What differentiates an HMO from a PPO?

- A. An HMO requires members to choose a primary care physician
- B. A PPO requires referrals for specialists
- C. An HMO covers more out-of-network services
- D. A PPO has a lower deductible

An HMO, or Health Maintenance Organization, is characterized by its requirement for members to select a primary care physician (PCP). This PCP serves as the main point of contact for all healthcare needs and is responsible for coordinating all care within the HMO network. Members must go through their PCP for referrals to see specialists, making the process more centralized and typically simpler. This structure promotes a more managed and preventive approach to healthcare, often leading to lower costs for members due to the agreements that HMOs have with network providers. Therefore, the requirement of having a primary care physician is fundamental to the way HMOs operate and is a key distinction from other plan types, such as PPOs (Preferred Provider Organizations), which offer more flexibility in choosing healthcare providers without the need for a referral. In the context given, the other options reflect features of PPOs or general misconceptions about how these plans operate, but they do not accurately describe the defining characteristics that separate HMOs from PPOs.

8. How must an applicant demonstrate knowledge to be licensed in accident and health insurance in North Carolina?

- A. Pass a set of practice tests
- B. Complete 20 hours of approved instruction
- C. Provide prior work experience
- D. Pass a background check

To be licensed in accident and health insurance in North Carolina, an applicant must complete 20 hours of approved instruction. This requirement ensures that the applicant has a foundational understanding of insurance principles, regulations, policy types, and other essential topics regarding accident and health insurance. Completing this educational requirement prepares the applicant for the responsibilities they will undertake as a licensed insurance agent. While practice tests may be useful for preparation, they do not fulfill the training requirement necessary for licensing. Prior work experience is not a substitute for formal education mandated by the state, and a background check, while a standard procedure for ensuring candidate suitability and integrity, does not provide the specific knowledge needed for the field. Thus, the completion of the specified number of hours in approved instruction is critical for ensuring that the applicant has a competent level of understanding before being entrusted to serve clients in the accident and health insurance sector.

9. What is a "rider" in an insurance policy?

- A. An addition to a basic policy that modifies its coverage or terms**
- B. A type of insurance policy specifically for high-risk individuals
- C. A standard procedure in processing health insurance claims
- D. A legal requirement for insurance companies to disclose risks

A rider in an insurance policy refers to an addition that modifies the coverage or terms of the base policy. This means that policyholders can customize their insurance by attaching riders that provide extra benefits or change aspects of their existing coverage. For example, a rider might extend benefits for certain conditions, provide coverage for specific treatments, or alter the terms under which a policy pays out. This customization aspect is essential as it allows individuals to tailor their insurance to meet their specific needs rather than being confined to a static set of coverage options. Riders can enhance protection or provide additional coverage that isn't included in the main policy, making them a valuable part of many insurance contracts. The other options do not accurately capture the essence of what a rider is. While there are specialized policies for particular situations, such as high-risk individuals, those do not represent the concept of a rider. Similarly, claim processing procedures and disclosure requirements do not pertain to the modifications of a policy itself but rather to the operations of insurance as a whole.

10. Which statement is true regarding a group accident and health policy issued to an employer?

- A. The employer keeps the policy while employees receive nothing
- B. Each employee is issued a direct contract with the insurer
- C. The employer receives the policy and each employee is issued a certificate**
- D. All employees share a single policy document

The statement that the employer receives the policy and each employee is issued a certificate is accurate for group accident and health policies. In these policies, the employer typically holds the master policy, which outlines the coverage terms, benefits, and conditions of the insurance. Each employee covered under the plan receives a certificate of insurance, which serves as proof of coverage and details the benefits they are entitled to as part of the group policy. This structure allows the employer to manage the policy while still ensuring that employees have documentation of their individual coverage rights and benefits. The certificate simplifies communication about the policy's provisions without requiring every employee to hold a separate contract with the insurance provider. This setup also indicates collective risk management, as policies are designed for groups, typically resulting in better rates and coverage options compared to individual policies.

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://ncaccidenthealth.examzify.com>

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

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