

OREGON LIFE AND HEALTH INSURANCE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

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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. Under most insurance policies, what constitutes a 'total disability'?**
 - A. The inability to perform any work for which the insured is qualified due to injury or sickness
 - B. The inability to perform daily activities independently
 - C. The inability to work for a specific period
 - D. The inability to receive treatment for a health condition
- 2. Which of the following best defines 'underwriting' in insurance?**
 - A. The process of selecting and classifying risks
 - B. The assessment of claims
 - C. The marketing of an insurance policy
 - D. The management of premiums
- 3. What is a characteristic of the pure life annuity settlement option?**
 - A. The beneficiary will receive a refund of the principal
 - B. It guarantees income for a specified period of time
 - C. It provides the highest monthly benefit
 - D. It guarantees that all proceeds will be paid out
- 4. What happens to the face amount of a whole life policy if the insured reaches the age of 100?**
 - A. The cash value and the face amount are paid to the insured
 - B. The face amount is paid to the insured
 - C. It is paid to the insured's estate and the policy is terminated
 - D. It is paid to the beneficiary in full
- 5. What is it called when a doctor accepts the Medicare approved amount?**
 - A. Assignment
 - B. Consent
 - C. Verification
 - D. Acceptance

- 6. Which of the following time periods is the general enrollment period for Medicare Part B?**
- A. March 1 through March 31 each year
 - B. January 1 through March 31 each year
 - C. March 1 through May 31 each year
 - D. January 1 through January 31 each year
- 7. What is the required grace period for life insurance premiums in Oregon?**
- A. 15 days
 - B. 30 days
 - C. 60 days
 - D. 90 days
- 8. What is a major benefit of group health insurance?**
- A. Higher premiums
 - B. More complicated enrollment processes
 - C. Typically more cost-effective and easier to obtain
 - D. Individualized coverage options
- 9. In health insurance, what is a 'network'?**
- A. A list of all healthcare services covered by a policy
 - B. A group of healthcare providers who have agreed to provide services at negotiated rates
 - C. A database for tracking patient claims and payments
 - D. A team of specialists assigned to high-risk patients
- 10. To be acceptable to insurance companies, what percentage of eligible employees must be enrolled under a contributory group health insurance plan?**
- A. 65%
 - B. 75%
 - C. 100%
 - D. 50%

Answers

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

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Explanations

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1. Under most insurance policies, what constitutes a 'total disability'?

- A. The inability to perform any work for which the insured is qualified due to injury or sickness
- B. The inability to perform daily activities independently
- C. The inability to work for a specific period
- D. The inability to receive treatment for a health condition

Total disability in insurance terms is generally defined as the insured's inability to perform any work for which they are qualified due to injury or sickness. This definition focuses on the individual's capacity to engage in work that they are trained for or have experience in, regardless of the type of employment that may be available. It reflects the insured's complete loss of ability to work in their specific field or any other field they might be qualified for, largely influencing how benefits are calculated and provided. If an individual cannot perform any work due to their medical condition, this situation meets the criteria for total disability, thereby allowing them to access relevant benefits under their insurance policy. This concept is critical in determining eligibility for disability benefits and is a key factor in many policy definitions. The other options typically describe aspects of disability but do not align with the conventional definition of total disability as understood in most insurance contexts. For instance, the inability to perform daily activities independently may refer to functional limitations but does not specifically address the work-related capacity necessary for assessing total disability benefits.

2. Which of the following best defines 'underwriting' in insurance?

- A. The process of selecting and classifying risks
- B. The assessment of claims
- C. The marketing of an insurance policy
- D. The management of premiums

Underwriting in insurance is primarily defined as the process of selecting and classifying risks. This involves evaluating the potential risks associated with an insurance applicant to determine whether the insurer will accept the risk and at what premium rate. Underwriters analyze various factors, including the applicant's age, health history, occupation, and lifestyle choices to assess the probability of a claim being made. This process is crucial because it helps insurance companies maintain a balanced risk pool and ensures premium amounts are appropriately aligned with the risk taken on by the insurer. By accurately classifying risks, insurers can also establish appropriate underwriting guidelines that dictate which applicants qualify for coverage and under what terms. Understanding this process lays the foundation for comprehending how insurance rates are calculated and how insurance products are tailored to meet client needs.

3. What is a characteristic of the pure life annuity settlement option?

- A. The beneficiary will receive a refund of the principal
- B. It guarantees income for a specified period of time
- C. It provides the highest monthly benefit**
- D. It guarantees that all proceeds will be paid out

The pure life annuity settlement option is characterized by its provision of the highest monthly benefit available to the annuitant. This option is designed to pay the annuitant a steady stream of income for as long as they live, starting at the time of annuitization. Since payments cease upon the death of the annuitant, this structure maximizes the monthly payout amount relative to other options, such as those that may guarantee a minimum payment period or provide for a beneficiary. In contrast, options that involve a refund of principal or a guaranteed payout to beneficiaries often entail reducing the monthly benefit amount because the insurance company has to account for the potential additional payouts beyond the annuitant's lifetime. Therefore, the pure life annuity option stands out as offering the highest monthly benefit compared to options that include these additional guarantees. This focus on maximizing income for the lifetime of the annuitant underscores the essence of the pure life annuity's appeal.

4. What happens to the face amount of a whole life policy if the insured reaches the age of 100?

- A. The cash value and the face amount are paid to the insured
- B. The face amount is paid to the insured**
- C. It is paid to the insured's estate and the policy is terminated
- D. It is paid to the beneficiary in full

In a whole life insurance policy, if the insured reaches the age of 100, the policy matures, and the face amount is paid out to the insured. This outcome reflects the inherent design of whole life policies, which are intended to provide insurance coverage for the lifetime of the insured. When the insured lives to the maturity age, they are entitled to receive the death benefit as they have essentially lived beyond the period for which the company anticipated having to pay a death claim. While some policies might offer other cash values or options upon maturity, the key point is that the insured receives the face amount directly. This feature underscores the policy's commitment to financial security throughout the insured's lifetime, ensuring that the coverage holds value regardless of when the policy matures due to the insured reaching 100 years of age.

5. What is it called when a doctor accepts the Medicare approved amount?

- A. Assignment**
- B. Consent
- C. Verification
- D. Acceptance

When a doctor accepts the Medicare approved amount, this is referred to as "assignment." This means that the healthcare provider agrees to accept the Medicare fee schedule as full payment for the services rendered to the patient. By accepting assignment, the doctor typically agrees to bill Medicare directly and receive payment directly from Medicare, which can alleviate the financial burden on the patient. This process is beneficial for patients, as it often means lower out-of-pocket costs for them, as they are responsible only for any applicable copayments, deductibles, and coinsurance, rather than paying the full fee billed by the provider. Additionally, when a provider accepts assignment, they cannot charge the patient more than the Medicare-approved amount for the service, ensuring transparency and affordability in healthcare costs.

6. Which of the following time periods is the general enrollment period for Medicare Part B?

- A. March 1 through March 31 each year
- B. January 1 through March 31 each year**
- C. March 1 through May 31 each year
- D. January 1 through January 31 each year

The correct answer is January 1 through March 31 each year, which is recognized as the general enrollment period for Medicare Part B. During this time, individuals who did not sign up for Medicare Part B during their initial enrollment period can enroll in the program. This is crucial for beneficiaries as it allows them access to medical insurance, covering necessary services like physician visits and outpatient care. During this designated period, beneficiaries need to be aware that coverage will not begin immediately; instead, if they enroll during the general enrollment period, their coverage will begin on July 1 of that year. Understanding this timeframe is essential for individuals approaching eligibility for Medicare to avoid any potential coverage gaps. The timeframes listed in the other options do not correspond with the Medicare policies in place, making them inaccurate for this question's context.

7. What is the required grace period for life insurance premiums in Oregon?

- A. 15 days
- B. 30 days**
- C. 60 days
- D. 90 days

In Oregon, the required grace period for life insurance premiums is indeed 30 days. This means that if a policyholder fails to pay their premium on or before the due date, they have an additional 30 days to make the payment without risking the lapse of their policy. During this grace period, the policy remains in effect, allowing the insured to maintain coverage and provide protection for their beneficiaries. This provision is important as it offers policyholders some leeway to manage unexpected financial difficulties without immediately facing the consequences of losing their insurance coverage. The grace period is a standard practice that reflects the understanding that circumstances can arise that may delay a premium payment, and it is designed to provide consumers with reasonable accommodations to protect their ongoing insurance needs.

8. What is a major benefit of group health insurance?

- A. Higher premiums
- B. More complicated enrollment processes
- C. Typically more cost-effective and easier to obtain**
- D. Individualized coverage options

The primary advantage of group health insurance lies in its cost-effectiveness and accessibility. Group policies are usually offered by employers or organizations that bring together many members, allowing the risk to be spread across a larger pool. This collective approach often results in lower premiums for individuals when compared to purchasing individual plans. Additionally, group plans typically have simpler enrollment processes, making it easier for individuals to obtain coverage without needing to go through extensive medical underwriting, which can be a barrier in individual insurance markets. This coverage structure also promotes a sense of community and shared benefit among members, as employees or members can often access comprehensive health care benefits without the burden of high out-of-pocket expenses. The ease of securing coverage and the financial advantages of participating in a group plan make this option appealing for many individuals.

9. In health insurance, what is a 'network'?

- A. A list of all healthcare services covered by a policy
- B. A group of healthcare providers who have agreed to provide services at negotiated rates**
- C. A database for tracking patient claims and payments
- D. A team of specialists assigned to high-risk patients

In health insurance, a network refers to a group of healthcare providers who have agreed to offer their services at negotiated rates. This arrangement typically allows insurance companies to control costs and provide policyholders access to a range of doctors, hospitals, and specialists who are part of that network. By utilizing in-network providers, policyholders often pay lower out-of-pocket costs when seeking medical care compared to going out of network, where costs usually increase significantly. This concept is foundational in many health insurance plans, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), as it helps both the insurance provider and the insured manage expenses while ensuring that patients have access to quality care. The partnerships formed between the insurance companies and the providers within the network facilitate this cooperative cost management. The other options presented do not fully represent the definition of a network within health insurance. A list of healthcare services covered by a policy relates more to the scope of benefits rather than the relationship between providers and insurers. A database for tracking patient claims and payments refers to administrative functions rather than the clinical relationships involved in healthcare delivery. The concept of a team of specialists assigned to high-risk patients pertains to case management in healthcare, which is a different operational function.

10. To be acceptable to insurance companies, what percentage of eligible employees must be enrolled under a contributory group health insurance plan?

- A. 65%
- B. 75%**
- C. 100%
- D. 50%

In the context of a contributory group health insurance plan, insurance companies typically require a certain minimum percentage of eligible employees to participate in the plan for it to be considered acceptable. This requirement helps ensure that the risk pool is large enough and diverse enough to maintain financial viability and effective premium pricing for the insurance provider. The standard percentage for eligible employee enrollment in a contributory plan is often set at 75%. This means that at least three-quarters of the eligible employees must choose to enroll in the insurance plan for it to provide a balanced risk pool. When a higher percentage of employees enroll, it indicates a collective interest in the plan, which reduces the potential for adverse selection (where only those needing insurance would enroll). As a result, the probability of unexpected claims is minimized, making the plan stable and sustainable for the insurer. While options such as 65%, 100%, and 50% might seem feasible for certain situations or plans, they do not align with the typical industry standard for contributory group health insurance requirements. Thus, the correct answer reflects the regulatory or industry norm that balances participation and risk management effectively.

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://orlifeandhealth.examzify.com>

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

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