

Vermont Life, Accident & Health (LAH) Insurance Practice Exam (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

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- 1. What type of program is Medicaid?**
 - A. Federal program only**
 - B. State program only**
 - C. Joint federal-state program for low-income individuals**
 - D. Private insurance option for low-income families**
- 2. What is the main difference between group and individual health insurance plans?**
 - A. Group plans are typically cheaper and cover more services**
 - B. Individual plans cover pre-existing conditions by default**
 - C. Group plans generally require no medical underwriting**
 - D. Individual plans offer better access to specialists**
- 3. When can policy loans become available for an insurance policy?**
 - A. Immediately after purchase**
 - B. After cash value accumulates**
 - C. Only after 5 years**
 - D. Upon request**
- 4. Who determines the premium rates in an insurance policy?**
 - A. The policyholder**
 - B. The insurance agent**
 - C. The underwriter**
 - D. The beneficiary**
- 5. Which factor is commonly assessed in determining insurability?**
 - A. Type of employment**
 - B. Education level**
 - C. Health history and risk factors**
 - D. Age alone**

6. What constitutes a prohibited practice regarding misrepresentation in insurance?

- A. Providing incomplete policy details**
- B. Lying about terms, benefits, or advantages of policies**
- C. Filing false claims for benefits**
- D. Forgetting to disclose policy exclusions**

7. What is the function of a health savings account (HSA)?

- A. To pay life insurance premiums**
- B. To save for retirement expenses**
- C. To accumulate funds for medical expenses on a tax-advantaged basis**
- D. To invest in stocks and bonds**

8. Which type of services are typically covered at 100% in most health insurance plans?

- A. Major services**
- B. Diagnostic and preventive services**
- C. Emergency services**
- D. Prescription drug services**

9. What is a key feature of whole life insurance?

- A. This insurance type is typically cheaper than term life**
- B. It includes a cash value component**
- C. It only pays out if the insured dies within a set time frame**
- D. This type has no guaranteed payout**

10. What is the primary role of the Vermont Life Guaranty Association?

- A. To regulate life insurance companies.**
- B. To protect life insurance and annuity holders if an insurer fails.**
- C. To provide health insurance to residents.**
- D. To monitor insurance premium rates.**

Answers

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

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Explanations

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1. What type of program is Medicaid?

- A. Federal program only
- B. State program only
- C. Joint federal-state program for low-income individuals**
- D. Private insurance option for low-income families

Medicaid is classified as a joint federal-state program designed to provide healthcare coverage to low-income individuals. This means that the program is funded and administered by both the federal government and individual state governments, allowing for variations in how the program operates and what services are covered depending on the state. The federal government sets certain guidelines and provides funding, while states have the flexibility to design their own programs within those guidelines, determining eligibility criteria, benefits, and managing the delivery of care. This structure allows Medicaid to address the needs of diverse populations across different states, ensuring that low-income individuals, families, the elderly, and individuals with disabilities can access necessary medical services. The collaborative approach also helps to tailor the program to local needs, while still maintaining a level of uniformity across the nation in terms of fundamental goals, such as reducing the number of uninsured individuals and providing access to necessary healthcare services. The other options do not accurately describe Medicaid's nature, as it cannot be classified solely as a federal or state program, nor is it a private insurance option.

2. What is the main difference between group and individual health insurance plans?

- A. Group plans are typically cheaper and cover more services
- B. Individual plans cover pre-existing conditions by default
- C. Group plans generally require no medical underwriting**
- D. Individual plans offer better access to specialists

The main difference between group and individual health insurance plans lies in the underwriting process. Group plans generally do not require medical underwriting, meaning that all eligible members of the group can be accepted into the plan regardless of their health status. This characteristic is a significant advantage of group insurance, as it allows employers or organizations to provide coverage to their employees or members without the risk of excluding individuals due to pre-existing conditions. In contrast, individual plans often involve a detailed underwriting process, which may assess an individual's health history and could lead to higher premiums or denial of coverage based on pre-existing conditions. This distinction makes group plans more inclusive, allowing for a broader range of individuals to obtain coverage without the barriers that individual plans may present. Additionally, while group plans can often be more cost-effective and cover a wide array of services due to the pooling of risk among a large number of members, which helps reduce costs, this is not universally true for every situation. Individual plans do tend to allow for more tailored coverage options and may provide better access to specialists depending on the specific plan chosen. However, these factors do not invalidate the primary distinction related to the underwriting process in group plans.

3. When can policy loans become available for an insurance policy?

- A. Immediately after purchase
- B. After cash value accumulates**
- C. Only after 5 years
- D. Upon request

Policy loans become available for an insurance policy once cash value accumulates. This is a fundamental characteristic of permanent life insurance policies, such as whole life or universal life, which allow policyholders to build cash value over time. The cash value serves as a savings component that increases over the years and is accessible to the policyholder in the form of a loan. This accumulation process is essential; if there is no cash value built up, there would be no funds available to borrow against. Therefore, a policyholder must wait until the policy has accrued sufficient cash value before they can take out a loan. The other options lack an understanding of how cash value functions in life insurance. Loans cannot be taken immediately after purchase, as there is usually no cash value at that stage. The stipulation of a fixed 5-year period is also inaccurate, as the duration until cash value builds depends on the specific policy and the premiums paid. Lastly, a simple request does not suffice; the availability of the loan is intrinsically linked to the presence of cash value in the policy.

4. Who determines the premium rates in an insurance policy?

- A. The policyholder
- B. The insurance agent
- C. The underwriter**
- D. The beneficiary

The correct answer is that the underwriter determines the premium rates in an insurance policy. Underwriters play a crucial role in the insurance industry as they assess the risk associated with insuring an individual or entity. They evaluate various factors such as the applicant's health status, history, lifestyle, and other relevant information to determine the likelihood of a claim being made. Based on this assessment, the underwriter calculates the appropriate premium that reflects the level of risk posed by the policyholder. This process ensures that the premiums charged are aligned with the potential liabilities the insurance company may face. Underwriters work within guidelines set by the insurance company and take into account market conditions, regulatory requirements, and underwriting standards. Their expertise allows them to balance the need for competitive pricing with the financial sustainability of the insurance product. The other options, while related to the insurance process, do not directly determine premium rates. The policyholder is the individual purchasing the insurance, but they do not set the rates. The insurance agent may advise on policies and facilitate the purchase, but they do not have the authority to determine premium amounts. The beneficiary is the person who receives the benefits of the policy upon the occurrence of an insured event; they are not involved in the underwriting or premium-setting process.

5. Which factor is commonly assessed in determining insurability?

- A. Type of employment
- B. Education level
- C. Health history and risk factors**
- D. Age alone

Health history and risk factors are essential components in determining an individual's insurability. Insurance companies evaluate these factors to assess the likelihood of a claim being made during the policy's term. A person's medical history, including pre-existing conditions, lifestyle choices such as smoking or alcohol consumption, and any potential hereditary issues, provide insight into their overall health profile and risk level. This helps insurers set appropriate premiums and coverage terms, ultimately ensuring that they can manage risk effectively while providing appropriate protection to the insured. While factors such as type of employment, education level, and age may contribute to understanding a person's risk profile, they do not give as direct and comprehensive insight into health-related risks as health history and risk factors do. Health conditions and behaviors have a more predictable relationship with insurance outcomes, which is why they are critically assessed during the underwriting process.

6. What constitutes a prohibited practice regarding misrepresentation in insurance?

- A. Providing incomplete policy details
- B. Lying about terms, benefits, or advantages of policies**
- C. Filing false claims for benefits
- D. Forgetting to disclose policy exclusions

In the context of insurance regulations, misrepresentation refers to making false or misleading statements regarding a policy. This includes any act of dishonesty that can lead potential clients to have incorrect perceptions about a policy's actual terms, benefits, or advantages. When an agent or insurer lies about the features of a policy, it can severely impact a consumer's decision-making process, leading them to purchase a policy based on false information. This not only harms the consumer but can also undermine the integrity of the insurance industry as a whole. The other options, while they also represent unethical practices, fall under different categories. Providing incomplete policy details could mislead individuals, but it is not as direct an act of misrepresentation as outright lying. Filing false claims constitutes fraud, while forgetting to disclose policy exclusions might lead to misunderstanding but does not involve a deliberate misstatement regarding the policy's characteristics. Thus, the act of lying about the terms, benefits, or advantages stands out as a clear and egregious form of misrepresentation, fitting the definition within insurance regulations.

7. What is the function of a health savings account (HSA)?

- A. To pay life insurance premiums**
- B. To save for retirement expenses**
- C. To accumulate funds for medical expenses on a tax-advantaged basis**
- D. To invest in stocks and bonds**

A health savings account (HSA) is specifically designed to accumulate funds for medical expenses in a tax-advantaged way. Individuals can contribute money to an HSA and use these funds to pay for qualified medical expenses, such as deductibles, copayments, and other out-of-pocket healthcare costs. Contributions to an HSA are typically tax-deductible, and the funds can grow without being taxed as long as they are used for eligible medical expenses. This unique tax treatment makes HSAs a powerful tool for managing healthcare costs, as they encourage saving for medical expenses while also providing tax benefits. By allowing contributions to be made with pre-tax dollars and offering tax-free withdrawals for qualified medical expenditures, HSAs not only assist individuals in managing current healthcare expenses but also promote saving for future medical needs.

8. Which type of services are typically covered at 100% in most health insurance plans?

- A. Major services**
- B. Diagnostic and preventive services**
- C. Emergency services**
- D. Prescription drug services**

In most health insurance plans, diagnostic and preventive services are often covered at 100%. This coverage typically includes routine check-ups, vaccinations, screenings, and other preventive care meant to maintain health and catch any potential health issues early when they are most treatable. The rationale behind this complete coverage is to encourage individuals to engage in regular health maintenance and proactively manage their health, ultimately reducing long-term healthcare costs. Major services, such as surgeries or complex treatments, often involve co-pays or deductibles because they are more costly and not considered preventive in nature. Emergency services, while crucial and often covered, may have stipulations regarding co-pays or out-of-pocket costs. Prescription drug services typically require co-pays or coinsurance, making them distinct from the fully covered preventive care services. This structure emphasizes the value placed on prevention and early detection in health plans, promoting a healthier population overall.

9. What is a key feature of whole life insurance?

- A. This insurance type is typically cheaper than term life
- B. It includes a cash value component**
- C. It only pays out if the insured dies within a set time frame
- D. This type has no guaranteed payout

Whole life insurance is characterized by its cash value component, which distinguishes it from term life insurance. As policyholders pay their premiums, a portion of these payments builds up as cash value over time. This cash value can grow at a guaranteed rate and may also accumulate dividends, depending on the policy. The presence of this cash value allows policyholders not only to have life insurance coverage for their entire lifetime, as long as premiums are paid, but also to borrow against this value or withdraw funds during their lifetime if needed. This dual benefit of lifelong coverage combined with the potential for cash value accumulation is a fundamental aspect of whole life insurance, making this choice the most accurate description of its key feature.

10. What is the primary role of the Vermont Life Guaranty Association?

- A. To regulate life insurance companies.
- B. To protect life insurance and annuity holders if an insurer fails.**
- C. To provide health insurance to residents.
- D. To monitor insurance premium rates.

The primary role of the Vermont Life Guaranty Association is to protect life insurance and annuity holders if an insurer fails. This association acts as a safety net for policyholders, ensuring that even in the unfortunate event of an insurance company going bankrupt or becoming insolvent, the financial interests of policyholders are safeguarded. It provides a measure of reassurance to consumers, as it plays a critical role in maintaining confidence in the insurance industry. The association typically covers policies up to a certain limit, allowing policyholders to recover some or all of their benefits. This protection is essential for maintaining stability in the insurance market and provides peace of mind for individuals who rely on life insurance and annuity products for their financial security. While the regulation of life insurance companies, providing health insurance, and monitoring premium rates are important functions in the insurance market, they fall outside the specific mandate of the Vermont Life Guaranty Association, which is focused solely on protecting the interests of policyholders in the event of insurer failure.

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://vermontlahinsurance.examzify.com>

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

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