Oklahoma Life, Accident, and Health or Sickness Producer Exam

Insurance Licensing Ok-Life-Accident-and-Health-or-Sickness-Producer

Version Demo

Total Demo Questions: 17

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Topic Break Down

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Topic 1, GENERAL INSURANCE	15
Topic 2, LIFE INSURANCE	72
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Total	177

QUESTION NO: 1

The primary reason for purchasing life insurance is to provide

A. tax deduction.

B. death benefits.

C. retirement income.

D. safety of principal.

ANSWER: B

Explanation:

Death benefits are the primary reason for purchasing life insurance. A life insurance policy creates a contractual promise that, when the insured dies while coverage is in force, the insurer will pay the policy's stated death benefit to the named beneficiary or beneficiaries. This payment is intended to address the financial consequences of the insured's death, such as replacing lost income, paying final expenses, servicing debts, funding education, or helping preserve a family's financial stability. The policyowner selects the amount of coverage and designates the beneficiary, allowing the proceeds to be directed to the individuals or entities with an insurable interest or financial need related to the loss. Although certain life insurance contracts may accumulate cash value and can sometimes be used in broader financial planning, the defining insurance function remains protection against the economic loss caused by premature death. Oklahoma insurance law defines life insurance as insurance on human lives and recognizes benefits payable upon death; this reflects the central role of death-benefit protection in life insurance coverage. See Oklahoma Statutes, Title 36—Insurance and the National Association of Insurance Commissioners' life insurance consumer guidance.

QUESTION NO: 2

To apply for a life or health insurance policy,

A. the insured must report all information about family illnesses.

B. a physical examination must be performed by a licensed physician.

C. all possible serious medical conditions must be diagnosed and recorded.

D. the insured individualâ€™s medical history may be reviewed and reported.

ANSWER: D

Explanation:

"the insured individualâ€™s medical history may be reviewed and reported" is correct because life and health insurers use medical underwriting to evaluate the proposed insuredâ€™s risk before deciding whether to issue coverage and on what terms. An application may request information about current health, prior illnesses, treatment, medications, physicians, hospitalizations, and other relevant medical history. The insurer may also obtain additional medical information, when authorized, through sources such as attending-physician statements, medical-information databases, prescription-history reports, or a medical examination when its underwriting rules call for one. The information is used to assess the likelihood and expected cost of insured losses and must be handled subject to applicable privacy requirements. Applicants should provide complete, truthful responses to questions asked on the application, since a material misrepresentation in an insurance application can affect coverage or an insurerâ€™s obligations under the policy. Oklahoma law specifically addresses the effect of misrepresentations, omissions, concealment of facts, and incorrect statements in life and health insurance applications. See 36 O.S. § 3611. For general information on how medical information may be used in health-insurance coverage decisions, see the U.S. Department of Health and Human Services HIPAA Privacy Rule resources.

QUESTION NO: 3

Modified whole life policies are distinguished by premiums that are

A. lower than typical whole life premiums during the last few years.

B. higher than typical whole life premiums during the last few years.

C. lower than typical whole life premiums during the initial years and then higher thereafter.

D. higher than typical whole life premiums during the initial years and then lower thereafter.

ANSWER: C

Explanation:

“lower than typical whole life premiums during the initial years and then higher thereafter” is correct because modified whole life insurance is a form of traditional whole life coverage designed with an introductory premium structure. The policyowner pays a reduced, level premium for a specified initial period, commonly the first few years. After that period ends, the premium increases to a higher level amount and generally remains level for the rest of the insured’s life, assuming premiums are paid as required. Like other whole life policies, modified whole life provides permanent life insurance protection and builds cash value under its contractual terms; the distinguishing feature is the scheduled change from an initially lower premium to a later, higher premium. This structure can make permanent coverage more accessible when the policy is first purchased, while recognizing that the cost is higher after the introductory period. The National Association of Insurance Commissioners’ consumer material describes whole life as permanent insurance with level premiums, while modified whole life is a recognized variation whose premium pattern is modified during its early duration. See the NAIC Life Insurance consumer guide and the Oklahoma Insurance Department’s consumer and licensing resources.

QUESTION NO: 4

Credit and accident disability plans are designed to

A. replace an employeeâ€™s income.

B. help an insured pay off a loan in the event of an accident or sickness.

C. pay medical and dental premiums for the insured.

D. pay for legal actions against the insured.

ANSWER: B

Explanation:

Credit and accident disability plans are designed to “help an insured pay off a loan in the event of an accident or sickness.” This coverage is tied to a specific consumer credit obligation rather than to the insured’s general income or medical expenses. If a covered disability occurs, the insurer provides benefits intended to meet the insured debtor’s scheduled loan payments, or otherwise reduce or satisfy the outstanding debt, subject to the policy’s benefit limits and conditions. The creditor is commonly the beneficiary of the payment because the insurance protects repayment of the credit transaction, while the debtor receives the important protection of avoiding missed payments during a qualifying disability. Oklahoma’s credit insurance laws define credit accident and health insurance as insurance on a debtor that provides indemnity for payments becoming due on a specific credit transaction if the debtor is disabled because of sickness or bodily injury. That statutory purpose directly matches helping the insured meet or pay off the covered loan obligation. See Oklahoma Statutes, Title 36, Section 4103 and the Oklahoma Insurance Department’s official consumer and insurance-regulation resources.

QUESTION NO: 5

Transacting insurance includes any of the following EXCEPT

A. selling insurance.

B. preliminary negotiations.

C. delivering insurance contracts.

D. gathering prospective buyer information.

ANSWER: D

Explanation:

"Gathering prospective buyer information" is the correct exception because obtaining lead or contact information, by itself, is not one of the statutory acts that constitute transacting insurance in Oklahoma. Oklahoma's definition of transacting insurance encompasses the insurance-related conduct involved in bringing a contract into existence and administering matters arising from it: solicitation and inducement, preliminary negotiations, effectuation of the insurance contract, and transactions subsequent to execution that arise from the contract. Selling insurance and conducting preliminary negotiations plainly fall within those activities. Delivering an insurance contract may be part of effectuation of the contract and therefore is conduct associated with transacting insurance. In contrast, a person who merely compiles names, contact details, or other prospective-customer information has not necessarily solicited, negotiated, effected, or serviced insurance. The activity remains outside transacting insurance so long as it is limited to lead generation or information gathering and does not involve communications or conduct intended to induce a particular person to purchase insurance. This distinction is important because Oklahoma producer-licensing requirements apply to persons engaging in insurance transactions, rather than to a person performing only nonsolicitation administrative or marketing-data functions. See Oklahoma's statutory definition at 36 O.S. § 1435.2 and producer licensing resources from the Oklahoma Insurance Department.

QUESTION NO: 6

Which of the following is an Unfair Claims Settlement Practices Act under Oklahoma law?

A. knowingly misrepresenting to a claimant pertinent facts or policy provisions that relate to coverage.

B. failing to interview all involved parties within 45 days of the filing of proof of loss forms.

C. not maintaining an audit trail of premium history and claim transactions.

D. failing to maintain complete policy notes involving claims.

ANSWER: A

Explanation:

"knowingly misrepresenting to a claimant pertinent facts or policy provisions that relate to coverage." is an unfair claims settlement practice under Oklahoma law. Oklahoma's Unfair Claims Settlement Practices Act specifically identifies knowingly misrepresenting pertinent facts or insurance-policy provisions relating to the coverage at issue as an unfair or deceptive act in the business of insurance. The rule focuses on what the insurer or its representative knows and communicates during claim handling: a claimant must receive truthful, accurate information about the relevant facts and the policy language that governs whether, and to what extent, a loss is covered. Accurate representation is essential because claimants rely on those statements when deciding whether to submit information, pursue benefits, accept a settlement, or exercise rights under the policy. This statutory requirement supports prompt, fair, and equitable resolution of claims and gives the Oklahoma Insurance Department authority to address prohibited claim-settlement conduct. The applicable provision is found at 36 O.S. § 1250.5, within Oklahoma's Unfair Claims Settlement Practices Act. See the Oklahoma Legislature's official statutory resources at Oklahoma Statutes by Title and the Oklahoma Insurance Department's official website for insurance regulatory information.

QUESTION NO: 7

A common disaster provision states that if the beneficiary dies from the same accident as the insured individual, the insurer will proceed as if the

A. insured individual outlived the beneficiary.

B. beneficiary outlived the insured individual.

C. beneficiary and the insured individual died simultaneously.

D. beneficiary was never named on the policy.

ANSWER: A

Explanation:

insured individual outlived the beneficiary. A common-disaster provision, also called a survivorship provision, establishes how death proceeds are handled when the insured and a beneficiary die in the same accident or disaster and the order of death is uncertain. The provision treats the beneficiary as having died before the insured unless the beneficiary survived for the policy's stated period or there is sufficient proof that the beneficiary survived the insured. Consequently, the insurer administers the death benefit as though the insured outlived that beneficiary. This prevents proceeds from passing through the primary beneficiary's estate merely because the order of death cannot be established. The proceeds instead are payable under the policy's remaining beneficiary designation, such as to a contingent beneficiary, or according to the policy's settlement provisions if no eligible beneficiary remains. This approach is consistent with Oklahoma's Uniform Simultaneous Death Law treatment of life-insurance proceeds when there is no sufficient evidence of survivorship: the insured is deemed to have survived the beneficiary for purposes of distributing the policy proceeds. See Oklahoma's statutory text at 15 O.S. § 103 and the Oklahoma Insurance Department's official consumer and producer resources.

QUESTION NO: 8

The grace period is a period of time

A. after the premium is paid and before the policy is issued.

B. after the premium is received and before the policy is issued.

C. between the death of the insured individual and the payment of the benefits.

D. when the policyowner is protected from an unintentional lapse of the policy.

ANSWER: D

Explanation:

The correct answer is "when the policyowner is protected from an unintentional lapse of the policy." A grace period is a required policy provision that gives the policyowner additional time to pay a premium after its due date while coverage remains in force. Its purpose is to prevent an accidental or unintended loss of insurance protection simply because a premium payment is late. For Oklahoma life insurance policies, the statutory grace period is generally one month, but not less than 30 days, after the first premium; during this time, the policy continues in force. If the insured dies during the grace period, the insurer may deduct any overdue premium from the policy proceeds. Accident and health insurance policies also must include a grace-period provision, with the applicable period depending on the premium-payment frequency. This protection is important because it preserves continuous coverage and gives the policyowner a reasonable opportunity to make a late payment without immediately forfeiting contractual benefits. See Oklahoma's life-policy standard provisions statute at Oklahoma Statutes, Title 36 and the Oklahoma Insurance Department's official consumer and regulatory resources.

QUESTION NO: 9

Credit and accident disability plans are designed to

A. replace an employee's income.

B. help an insured pay off a loan in the event of an accident or sickness.

C. pay medical and dental premiums for the insured.

D. pay for legal actions against the insured.

ANSWER: B

Explanation:

Credit and accident disability plans are designed to help an insured pay off a loan in the event of an accident or sickness. This is insurance connected to a specific credit obligation, rather than a general-purpose disability-income policy. When a covered disability occurs, the benefit is structured to protect the debtor's scheduled loan payments or outstanding indebtedness, subject to the policy's terms, benefit limits, and any applicable waiting period. The coverage therefore helps prevent a disability from interrupting repayment of the insured's debt and protects the credit transaction for which the insurance was obtained.

Oklahoma's credit insurance law defines credit accident and health insurance as insurance on a debtor that provides indemnity for payments becoming due on a specific indebtedness when the debtor is disabled due to accident or sickness. That statutory purpose directly supports the loan-payment function described in the correct answer. The benefit is tied to the insured debt, not to unrestricted replacement of the insured's earnings or unrelated expenses. See 36 O.S. § 4103, definitions for credit insurance and the Oklahoma Insurance Department for Oklahoma insurance regulatory information.

QUESTION NO: 10

The provision that the policy and a copy of an application is endorsed upon or attached to the policy when issued is the

A. certificate.

B. policy summary.

C. entire contract.

D. application.

ANSWER: C

Explanation:

The correct answer is **entire contract.** The entire-contract provision establishes which documents make up the complete, enforceable insurance agreement between the insurer and the policyowner. For an individual life policy, Oklahoma law requires a provision stating that the policy, or the policy and the application if the application is attached when issued, constitute the entire contract. This protects both parties by identifying the full agreement in one place and preventing unattached statements or outside documents from being treated as contractual terms. The attached application may therefore be used as part of the contract, including for representations made by the applicant, but the provision that declares the policy and attached application to be the complete agreement is the entire-contract provision. Oklahoma's required life-policy provisions are set out in 36 O.S. § 4001. Comparable required health-insurance policy provisions, including the entire-contract requirement, appear in 36 O.S. § 4405. The wording in the question directly describes this mandatory contractual provision.

QUESTION NO: 11

Upon receipt of notice of claim, the insurance company will furnish to the claimant such forms for filing proof of loss within how many days?

A. 10

B. 15

C. 20

D. 30

ANSWER: B

Explanation:

15 is correct. Oklahoma's required accident and health insurance policy provisions state that, when an insurer receives notice of claim, it must provide the claimant with the forms ordinarily used for filing proofs of loss within 15 days. This

requirement is designed to allow an insured or beneficiary to promptly document the claim and begin the benefits-payment process. The period runs from the insurer's receipt of the notice of claim, so the producer and claimant should ensure that notice is sent through a method that can establish delivery when timing is important.

The proof-of-loss forms provision also supports efficient claim administration by identifying the information the insurer needs to evaluate coverage, the extent of loss, and the amount payable under the policy. Oklahoma incorporates this timing requirement among the standard provisions applicable to accident and health insurance policies. In an exam setting, the key phrase is "furnish to the claimant such forms for filing proof of loss"; that language calls for the 15-day statutory period. See Oklahoma's Insurance Code, Title 36, through the Oklahoma State Courts Network Title 36 index and the Oklahoma Legislature's official statutes title index.

QUESTION NO: 12

The elimination period in an individual disability insurance policy refers to the

A. length of time a policy will continue to pay for specific disabilities.

B. amount of time a disabled person must wait before benefits are paid.

C. point in time when benefits are exhausted.

D. period of time that benefits are still payable after an insurance company discontinues a policy.

ANSWER: B

Explanation:

The correct answer is **"amount of time a disabled person must wait before benefits are paid."** In individual disability income insurance, the elimination period is a stated number of days that must pass after a covered disability begins before the insurer becomes obligated to pay benefits. It functions much like a time deductible: the insured absorbs the loss of income during that initial waiting period, assuming the disability continues long enough to satisfy the policy's requirements. Common elimination periods include 30, 60, 90, or 180 days, though the specific duration is selected in the policy contract. A longer elimination period generally shifts more initial loss exposure to the insured and can reduce the policy premium. The policy's definition of disability and its provisions governing how disability is measured and when the waiting period starts control the claim determination. This is a core disability-income policy provision tested in producer licensing because applicants must understand when income-replacement benefits actually become payable. The National Association of Insurance Commissioners describes disability income protection as coverage intended to replace income when an insured cannot work because of illness or injury; the elimination period establishes the initial delay before that replacement begins. See the NAIC consumer overview of disability income insurance and the Oklahoma Insurance Department for insurance regulatory resources.

QUESTION NO: 13

A new mother is guaranteed a 48-hour hospital stay after a regular delivery of a child under which federal law and regulations for group health insurance?

A. COBRA.

B. Medicaid.

C. HIPAA.

D. ERISA.

ANSWER: C

Explanation:

HIPAA. is correct because the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was enacted as part of the Health Insurance Portability and Accountability Act (HIPAA). NMHPA establishes important minimum maternity benefits for

group health plans and health insurance issuers. For a normal vaginal delivery, a plan generally may not restrict benefits for the mother or newborn child to a hospital stay of less than 48 hours. The corresponding minimum for a cesarean delivery is 96 hours. The attending provider, in consultation with the mother, may determine that an earlier discharge is appropriate; however, a plan cannot make benefits conditional on obtaining prior authorization for a stay within these federal minimum periods or otherwise pressure a mother to leave earlier.

For licensing-exam purposes, HIPAA is the federal-law answer associated with this maternity-stay protection. The rule safeguards both mother and newborn coverage and applies to group health coverage, subject to the federal regulatory framework governing those plans. The U.S. Department of Labor summarizes the NMHPA protections at Newborns' and Mothers' Health Protection Act. CMS also provides federal guidance on these protections at NMHPA Fact Sheet.

QUESTION NO: 14

An example of a false financial statement is which one of the following?

A. An insurance producer published an untrue newspaper advertisement about another producer.

B. An insurance producer posts information about a profitable insurer going bankrupt.

C. An insurance producer hands out flyers about another producer's criminal past.

D. An insurance producer mails out hateful postcards about a local insurer.

ANSWER: B

Explanation:

An insurance producer posts information about a profitable insurer going bankrupt. is a false financial statement when the posted bankruptcy information is untrue. Oklahoma's Unfair Trade Practices Act specifically prohibits making, publishing, disseminating, circulating, or placing before the public a statement that is false in a material respect concerning the financial condition of an insurer. An assertion that a financially sound, profitable insurer is bankrupt directly addresses that insurer's financial condition and could materially affect consumers' confidence, policy purchases, renewals, or decisions to surrender or replace coverage.

The rule protects both insurance consumers and the insurance marketplace from misleading financial rumors or representations. Bankruptcy, insolvency, and similar claims are especially significant because they suggest an insurer may be unable to pay policy benefits or meet contractual obligations. Therefore, communicating a false claim that an insurer is going bankrupt is the type of conduct covered by the statutory prohibition on false financial statements. The relevant Oklahoma provision is 36 O.S. § 1204, available at Oklahoma Statutes, Title 36, § 1204. Additional Oklahoma insurance regulatory information is available from the Oklahoma Insurance Department.

QUESTION NO: 15

Which of the following is NOT an example of inducement?

A. A promise of employment.

B. A gift having a value less than $100.

C. A special favor in the payment of premiums.

D. Giving merchandise to a client with a value of $250.

ANSWER: B

Explanation:

"A gift having a value less than $100." is the correct answer because Oklahoma's unfair trade practices statute permits limited gifts, articles of merchandise, or souvenirs when they meet the statutory value limit and are not used in a manner that unlawfully discriminates among insureds. In this context, a qualifying low-value gift is a permitted marketing or goodwill item rather than an unlawful inducement to buy insurance. The important exam concept is that Oklahoma generally prohibits

giving valuable consideration not specified in the insurance contract as an incentive connected with an insurance sale, but it expressly recognizes a limited exception for merchandise, gifts, and souvenirs with a value of no more than $100 per calendar year. The value threshold is therefore essential: a gift under that amount falls within the stated exception, provided the producer and insurer otherwise comply with the statute and applicable insurance regulations. This rule allows ordinary, modest promotional items while preserving the prohibition against sales incentives that could improperly influence an insurance purchase. Review the Oklahoma Insurance Code's unfair-trade-practices provisions, including 36 O.S. § 1204, in the Oklahoma Insurance Code. The Oklahoma Insurance Department's official website also provides regulatory and licensing resources.

QUESTION NO: 16

A Medicare beneficiary is treated in a hospital emergency department and remains under outpatient observation overnight. The beneficiary is not formally admitted as an inpatient. Which part of Original Medicare generally covers the physician services and outpatient hospital services?

A. Medicare Part A

B. Medicare Part B

C. Medicare Part C

D. Medicare Part D

ANSWER: B

Explanation:

Medicare Part B generally covers outpatient hospital services and physician services, including services received during outpatient observation. Medicare Part A primarily covers inpatient hospital care when the beneficiary has been formally admitted as an inpatient. An overnight stay does not by itself make the patient an inpatient; the beneficiary's admission status controls which part of Medicare generally applies.

QUESTION NO: 17

In terms of consideration, in which of the following circumstances is a health insurance contract effective?

A. When the insurance company provides the services promised in the contract.

B. When the insured pays the premium for a plan.

C. When the insured pays the premium and the policy is issued as applied for.

D. When the contract has been signed by both the insured and the insurance company.

ANSWER: C

Explanation:

"When the insured pays the premium and the policy is issued as applied for" is correct because an insurance contract requires consideration from both parties, along with an offer and acceptance. The applicant's consideration is the initial premium payment (or a valid promise to pay it), while the insurer's consideration is its promise to provide the coverage stated in the policy. Issuing the policy exactly as applied for represents the insurer's acceptance of the applicant's offer, so there is agreement on the coverage and the premium. At that point, assuming any stated conditions have been met, the policy is in force according to its effective-date provision. In practical insurance transactions, coverage can sometimes begin earlier under the terms of a properly issued conditional or binding receipt; however, where the policy is issued as applied for and the premium has been paid, the necessary consideration and acceptance are present. Oklahoma health insurance policy rules require policies to state essential contractual terms, including the parties, coverage, and premium-related information, reinforcing the importance of the issued policy as the insurer's contractual undertaking. See Oklahoma's health insurance policy provisions at Okla. Stat. tit. 36, § 4401 and consumer insurance information from the Oklahoma Insurance Department.