DUMPSARENA

ClaimCenter Business AnalystMammoth Proctored Exam

Guidewire ClaimCenter-Business-Analysts

Version Demo

Total Demo Questions: 6

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QUESTION NO: 1

Which workflow will kick in if the claim assignment is handled via "Default Group Claim Assignment Rule" with available matching?

A. Claim gets assigned to a user based on expertise and workload.

B. Claim gets assigned to an appropriate Group based on geography and LOB.

C. Claim gets assigned to a Supervisor to determine next step.

D. Claim goes to the "Root Group" for manual assignment.

ANSWER: A

Explanation:

Claim gets assigned to a user based on expertise and workload. The Default Group Claim Assignment Rule is used after ClaimCenter has established the assignment group and needs to select an appropriate individual within that group. With available matching enabled, the assignment process considers eligible users who are currently available for work and evaluates configured matching criteria for the claim. Those criteria can reflect an adjuster's relevant qualifications or expertise, as well as workload-related factors used to distribute work appropriately. The result is an automated assignment to a best-fit user in the selected group, rather than stopping at group-level routing. This supports ClaimCenter's assignment objective of directing claims to adjusters with the suitable skills and capacity while reducing manual triage. The precise matching fields, availability behavior, and load-balancing configuration are implementation-specific and are maintained as part of the insurer's ClaimCenter assignment configuration. Guidewire describes ClaimCenter as supporting automated claims workflows and assignment capabilities in its ClaimCenter product overview. For Guidewire-maintained product documentation and release-specific configuration guidance, see the Guidewire Documentation portal.

QUESTION NO: 2

An Adjuster at Succeed Insurance increases the reserve on a claim's exposure from $1,000 to $1,500 to account for inflation in repair costs. A week later, a Supervisor reviews the claim and wants to know specifically who made this change, the exact date and time it was made, and what the previous value was.

The Supervisor needs a chronological audit trail of changes to the claim file without navigating through complex financial ledgers.

Which screen in the ClaimCenter user interface should the Supervisor access to find this information?

A. Financials > Transactions

B. History

C. Notes

D. Loss Details > Status

ANSWER: B

Explanation:

History is the appropriate ClaimCenter screen because it provides the claim's chronological record of significant activity and field-level changes. When a user changes an exposure reserve, the history entry enables an authorized reviewer to identify the user who performed the action, when the update occurred, and the before-and-after values associated with the change. This gives the Supervisor an operational audit trail directly in the claim file, allowing efficient review of the adjustment without requiring financial-accounting analysis. Claim history supports accountability and supervisory review by preserving a time-ordered view of claim events and updates made during claim handling. In this scenario, the reserve increase is a claim-file change that the Supervisor needs to trace to a specific actor and timestamp, making the History screen the natural location for the review. Guidewire describes ClaimCenter as a system for managing the complete claim lifecycle and supporting adjuster work, including controlled, traceable claim processing. See the Guidewire ClaimCenter product overview and the Guidewire Documentation portal for ClaimCenter product and documentation resources.

QUESTION NO: 3

A sales executive and business traveler has a full coverage auto policy through his insurance company. The executive lives in Detroit, Michigan and often drives across the border to visit client offices in Canada.

While driving in downtown Toronto, the executive's car was hit by a truck coming the wrong way. He called his insurance company to report a claim for this accident. However, the Customer Service Representative (CSR) cannot confirm there is an active policy on file.

How should this claim be handled?

A. If the policy is not verifiable, the CSR will ask the executive to call back when he has the policy information to complete the report and create the claim.

B. If the policy is not verifiable, the CSR will create the claim as an unverified policy claim and retrieve the correct policy when more information available.

C. If the policy is not verifiable, the CSR will notify a Supervisor to escalate the case for investigation and submits notes in ClaimCenter for reference.

D. If the policy is not verifiable, the CSR cannot create the claim as a verified, active policy is a minimum requirement to create a claim.

ANSWER: B

Explanation:

If the policy is not verifiable, the CSR will create the claim as an unverified policy claim and retrieve the correct policy when more information available. ClaimCenter supports intake of a loss even when the policy cannot be located or verified during the initial customer contact. This capability lets the service representative capture the essential loss information promptly, including the incident, involved vehicle, parties, injuries, and location, without delaying the customer’s report because of a policy-search or integration issue. The claim is explicitly identified as having an unverified policy relationship, so it can proceed through appropriate follow-up and policy reconciliation once additional identifying information becomes available or the policy system can return a match. This approach preserves timely first-notice-of-loss handling while maintaining the distinction between a confirmed policy claim and one whose policy details still require validation. It is particularly appropriate when a customer reports an accident from outside the normal service area and the representative cannot immediately confirm active coverage. Guidewire describes ClaimCenter as a system supporting the complete claim lifecycle, beginning with first notice of loss and claim intake: Guidewire ClaimCenter. Guidewire product documentation is available through the Guidewire Documentation portal.

QUESTION NO: 4

What two pieces of information enable the Business Analyst (BA) to trace back to the root cause of an issue? (Choose two.)

A. The unique Story Card number associated with the acceptance criteria

B. The caution points indicated on the User Story Workflow

C. The change history on the Document Control tab of the Adjudicate - Create and Maintain Exposures for Vehicle User Story Card

D. The Approver Notes on the Acceptance tab of the Adjudicate - Create and Maintain Exposures for Vehicle User Story Card

E. The unique requirement numbers related to User Story

ANSWER: A E

Explanation:

The unique Story Card number associated with the acceptance criteria and the unique requirement numbers related to User Story provide the traceability identifiers needed to investigate an issue back to its business source. A Story Card number

identifies the specific business capability and its agreed scope, including the associated acceptance criteria. This gives the BA a reliable starting point for reviewing the intended user outcome, workflow context, and conditions of satisfaction that governed the implementation.

Unique requirement numbers add the necessary level of detail beneath that story context. They allow the BA to locate the precise requirement that describes the expected behavior, data, rule, or process outcome involved in the issue. By connecting an observed issue to both the story-level scope and the individual requirement, the BA can assess whether the implemented behavior aligns with the documented need and can follow the relationship through related design, configuration, development, and testing work items. This is the practical purpose of requirements traceability: maintaining verifiable links from a business need through delivery artifacts and validation evidence. Guidewire describes ClaimCenter as a configurable application whose implementation work is organized around defined business processes and application behavior; see the Guidewire ClaimCenter documentation. For general requirements-traceability principles applicable to BA work, see the IIBA BABOK Guide knowledge hub.

QUESTION NO: 5

Succeed Insurance allows field Adjusters to write checks directly to the insured to cover damage costs for minor claims such as:

Personal auto claims involving cracked windshields

Homeowners claims involving minor glass breakage

The Adjuster uses the Manual Check Wizard to record the check number and amount against a reserve line. Succeed requires Supervisor approval for all manual checks to ensure that the paper checks are verified against the payment information in ClaimCenter.

Which two limits or rules must be configured in ClaimCenter to ensure that these manual payments are sent to the correct person for approval? (Choose two.)

A. Approval routing rules

B. TransactionSet validation rules

C. Transaction approval rules

D. Authority limits

ANSWER: A C

Explanation:

Transaction approval rules are used to identify transaction sets that require approval based on business conditions. For this requirement, the rule can evaluate the manual-check transaction context and require approval whenever an adjuster records a manual payment, regardless of the payment amount. This makes the control consistent for the specified payment process and ensures that a check cannot simply proceed because its amount is small.

Approval routing rules then determine where the resulting approval request is assigned. They provide the routing logic needed to send the approval activity to the appropriate supervisor, using the organization's supervisory or assignment structure. Together, these configurations separate the business decision that a manual check needs review from the operational decision about which user receives that review task. This supports reconciliation of the physical check with the financial transaction recorded on the claim while retaining an auditable approval workflow. ClaimCenter's financial-management capabilities include payment controls and approval processing; see Guidewire ClaimCenter and the Guidewire Documentation portal.

QUESTION NO: 6

An Adjuster at Succeed Insurance is handling a personal auto claim for an insured who hit a tree after swerving to avoid a child who ran into the road.

The Adjuster has this Authority Limit Profile:

Limit Type	Policy Type	Coverage Type	Cost Type	Amount
Claim payments to date	Personal Auto			$5,000.00
Claim total reserves	Personal Auto			$5,000.00
Payments exceed reserves	Personal Auto			$500.00

The Adjuster creates a collision exposure and sets the initial reserves so that payments can be made to the insured for repairs to the damaged vehicle. No payments have been created yet.

The current financials for the claim are as follows:

Which two financial transactions will not require approval given that each option is the only transaction change rather than a cumulative change? (Choose two.)

A. A partial payment of $1,100 is made against the Expense - A&O - Vehicle inspection reserve line.

B. A partial payment of $2,000 is made against the Claim Cost - Auto body reserve line.

C. The Claim Cost - Auto body reserve line is increased to $6,000.

D. The Expense - A&O - Vehicle inspection reserve line is increased to $550.

ANSWER: B D

Explanation:

“A partial payment of $2,000 is made against the Claim Cost - Auto body reserve line.” does not require approval because the existing auto-body indemnity reserve is $2,500 and the proposed payment is fully supported by that reserve. The payment therefore does not create a payment-over-reserve amount, and total paid on the claim after this isolated transaction remains within the adjuster’s payment authority. ClaimCenter authority evaluation uses the financial impact of the transaction and the applicable authority profile limits to determine whether approval is needed.

“The Expense - A&O - Vehicle inspection reserve line is increased to $550.” also does not require approval. This change raises that reserve by only $50, resulting in total claim reserves of $3,050: $2,500 for auto-body claim cost plus $550 for the vehicle-inspection expense. That total remains below the $5,000 claim-total-reserves authority limit. Because the question specifies that each proposed change is evaluated independently rather than cumulatively, this reserve adjustment is assessed only against the claim’s current financial state and the adjuster’s assigned reserve authority.

These outcomes reflect ClaimCenter’s financial-controls model, in which reserves establish expected claim costs and authority limits govern when a user can commit financial changes without escalation. See the Guidewire ClaimCenter product overview and Guidewire Documentation.