

Test Alert!

Connecticut

Life, Accident, and Health Insurance

License Exam Manual, 3rd Edition
Pearson-Vue Exams Effective 6/1/08

6/18/08

L&H

The information included in this release, in addition to your other Kaplan Financial Education materials, is designed to assist you in preparing for concepts that your exam may include. We urge you to read it carefully and take time to review the sample questions and rationales.

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Part I

Changes to Text

On page 154, replace the last sentence of “2. Taxation of medical expense insurance” with the following:

Self-employed individuals may deduct all amounts paid for medical insurance, limited to the net earnings from self-employment in the business for which plan coverage was established. All other medical expenses are subject to the 7.5% floor.

On page 172, add the following content before “I. Connecticut Laws and Regulations Pertinent to Life, Accident, and Health Insurance”:

IMPORTANT: CHECK FOR UPDATES

License exam administration companies sometimes change topics on the insurance license exam unexpectedly or on short notice. To see whether we have issued an update for this product to accommodate a change in the exam, please go to www.kaplanfinancial.com. Click on View Insurance *TestAlerts!*, then click on your state to see a link to a portable document file (PDF) that you can download to study with your License Exam Manual. (If you do not see a *TestAlert!* listed for your state, we have not issued one.)

We suggest that you check now, sometime during your study period, when you’ve completed your study, and one last time just before you take your exam.

On page 173, change the last sentence of “5. Hearings” to the following:

If the violator knew (or should have known) the law was being violated, the fine will be not more than \$5,000 per act, not to exceed an aggregate of \$50,000 in any six-month period.

On page 173, insert the following content before “1. Insurance producer” and renumber succeeding paragraphs:

1. **Insurer [Sec. 38a-1(11)]** An insurer or insurance company is any person or entity, other than a fraternal benefit society, that transacts insurance business.
 - a. An alien insurer is one that is organized under the laws of a state or country outside the United States.
 - b. A domestic insurer is one that is organized under Connecticut law.

- c. A foreign insurer is one that is organized under the laws of another US state or territory.
- d. A mutual insurer is one without capital stock. Its members elect its managing directors or officers.
- e. An unauthorized entity or nonadmitted insurer is one that has not been granted a certificate of authority by the Commissioner to transact insurance business in Connecticut.

On page 174, change the citation in “d. License examination” to the following:

d. License examination [Secs. 38a-702d, 702e, 702f(c)]

On page 175, replace “g. Expiration and renewal “ with the following content:

- g. Expiration and renewal [Secs. 38a-702f(b), (c); 784]** A producer’s license renews biennially (every two years) on the producer’s birthday. Any producer who fails to renew must pay double the \$40 renewal fee (a total of \$80) to reinstate. Any insurer that cancels or does not renew an appointment must notify the agent, the agency, and the Insurance Department in writing within 30 days.

On page 182, insert the following content after “14. Appointment of producer as agent”:

- a. Notice to Commissioner** When the Commissioner receives a notice of appointment, he must within 30 days verify that the producer is eligible for appointment. If the Commissioner finds that the producer is ineligible for appointment, he must notify the insurer not later than five days after making the determination.

On page 184, replace the content of par. “a” in “6. Deadlines” with the following:

- a. Extensions for cause [Sec. 38a-782a-12]** In general, producers will not be granted extensions of time in which to earn continuing education credits. The only exception is for those whose military service prevents them from completing required continuing education within their compliance period.

On page 186, add the following content to “H. Filing and Approval of Policy Forms”:

- 4. Filing deadlines [Secs. 38a-480-8 to 10; 38a-481-1 to 4]** The Commissioner must acknowledge a form submitted for approval within 15 days of receipt and determine whether the filing is complete or not. Notice then follows to the insurer as to whether the filing is complete or deficient. The Commissioner has 75 days after receipt to either approve or disapprove of the form. If a filing is deficient, the Commissioner may extend the review period for 30 days but not more than 60 days to allow the insurer time in which to correct the filing.

On page 191, insert the following content before “N. Fair Credit Reporting Act”:

- 7. AIDs-specific questions in life and health insurance applications [Bulletin PF-16 (July 25, 1986)]** Applications for life or health insurance cannot inquire about a person’s exposure to Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), or AIDS-related conditions unless they use the following or substantially similar language:

Question: To the best of your knowledge and belief:

Have you ever had, been told you had, or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC), or AIDS-related conditions?

On page 191, add the following content after “N. Fair Credit Reporting Act”:

- O. Subrogation** When an insurance company pays a claim, it acquires the right to be indemnified by the party who caused the claim to arise. In terms of insurance, insurance companies gain the right to step into the insured’s place when they pay his claim, and they can then take legal action against any party from whom the insured could have otherwise sought recovery.

On page 202, add the following content after “C. Outline of Coverage”:

- D. Insurance Contracts: Proof of Loss and Payment of Claim [Sec. 38a-483(a)(7), (9)]** An insured must file a written proof of loss with the insurer’s office within 90 days of the loss. Failure to file proof of loss within this time does not impair the claimant’s right to payment if it was not reasonably possible to submit the claim within this

time, and if the claimant provides proof as soon as reasonably possible. However, proof of loss cannot be filed later than one year from the date of loss, unless the delay is due to mental incapacity.

Payment of claims will be made to designated beneficiaries and, if no such designation was made, then to the insured's estate. An insurer may pay medical claims directly to the providers unless the insured directs payment otherwise in writing. In any case, any payment made by the insurer in good faith fully discharges the insurer to the extent of the payment.

On page 203, insert the following content before "1. Dependent children coverage under individual policies" and renumber subsequent paragraphs:

- 1. Non-cancellable and guaranteed renewable policies [Sec. 38a-505-9]** A non-cancellable or guaranteed renewable policy cannot terminate coverage for a spouse due only to the occurrence of an event that will terminate coverage for the insured, other than nonpayment of premium. If the insured dies and the spouse is covered by the policy, the policy must make the spouse the insured.

On page 203, add the following content to "1. Dependent children coverage under individual policies":

Note: Beginning on January 1, 2009, coverage for dependent children under an individual policy may terminate no earlier than after the child marries or attains age 26 if a Connecticut resident (except for full-time attendance at an out-of-state college or university or out-of-state residence with a custodial parent), whichever occurs first.

On page 204, replace the heading of "2. Coverage of mentally or physically handicapped [Sec. 38a-489]" with "2. Coverage of mentally or physically handicapped [Secs. 38a-489, 515]" and add the following content:

The insurer may request proof of the child's continuing incapacity and dependency at any time. After two years have passed since the child reached the limiting age, the insurer may continue to require proof of continuing incapacity or dependency, but not more often than once every year.

On page 205, replace "7. Mammography coverage" with the following:

- 7. Mammography coverage [Sec. 38a-503, 504]** A baseline mammogram will be provided for women between the ages of 35 and 39, inclusive, and a mammogram every year for women who are 40 years old or older.

On page 205, replace the heading of “12. Mental disorders [Sec. 38a-514]” with “12. Mental disorders [Sec. 38a-488a, 514]” and add the following content:

A policy cannot place a greater financial burden on an insured for a diagnosis or treatment of mental or nervous conditions than it does for the diagnosis or treatment of medical, surgical, or other health conditions. If a policy pays benefits for the services of a licensed physician, it must pay the same benefits when the same services are lawfully rendered by a licensed psychologist, licensed clinical social worker, licensed marital and family therapist, licensed alcohol and drug counselor, or a licensed professional counselor.

On page 206, replace the heading of “15. Infertility coverage [Sec. 38a-536]” with “15. Infertility coverage [Secs. 38a-509, 536]” and add the following content:

Policies may limit coverage to a person until the person’s 40th birthday, or to persons who have been insured under the policy for at least 12 months.

On page 206, insert the following content before the first sentence of “2. Preexisting conditions”:

An insurance policy may not define a preexisting condition more restrictively than a condition for which an ordinarily prudent person would have sought diagnosis, care, or treatment within a five-year period before the effective date of coverage, or a condition for which medical advice or treatment was recommended by or received from a physician within a five-year period before the effective date of coverage.

On page 206, add the following content after “1. Preexisting conditions” and renumber subsequent paragraphs:

- 2. Time limit on certain defenses [Sec. 38a-483(a)(2)]** An insurer cannot contest the validity of a policy, except for nonpayment of premium, after it has been in force for two years following the date of issue.

On page 211, replace the heading for “N. Long-Term Care Insurance [Sec. 38a-501]” with “N. Long-Term Care Insurance [Regs. 38a-501-8, 24, 475, 476, 528-1 to 17]” and add the following content to “2. Marketing standards”:

- a. The insurance department will only approve long-term care policies that:
- advise the consumer that the Department of Social Services offers information and public education about long-term care insurance;
 - offer the option of home- and community-based services in addition to nursing home care;
 - include case management services in home care plans;
 - provide inflation protection; and
 - provide for the maintenance of records and explanation of benefits on insurance payments that count toward exclusions for purposes of eligibility for Medicaid and the Connecticut Partnership for Long-Term Care.

On page 211, replace the heading for “3. Outline of Coverage and Shopper’s Guide [Regs. 38a-501-18, 21]” with “3. Outline of Coverage and Shopper’s Guide [Regs. 38a-501-18, 21(b); 38a-528-11, 14(b)]” and add the following content:

The outline of coverage must be a separate document that is printed in a typeface that is no smaller than 12 points.

On page 212, add the following content to “9. Minimum benefits”:

- a. **Limitations and exclusions [Regs. 38a-501-11(d), 38a-528-4(d)]** An LTC policy can limit or exclude coverage for losses caused by
- war or acts of war;
 - mental disease or disorder that does not have a demonstrable organic cause;
 - suicide or attempted suicide while the insured is sane or insane;
 - intentionally self-inflicted injuries;
 - confinement in a government institution unless the insured is required to pay additional changes;
 - confinement due to alcoholism or drug addiction; or
 - confinement or care received outside of the United States.

A LTC policy may stipulate that it will not pay benefits that duplicate those that Medicare can pay.

- b. Exclusion for preexisting condition [Reg. 38a-501-11(b)]** A LTC policy cannot deny a claim for a loss that occurs more than six months before the effective date of the policy. The policy cannot define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
- c. Zero-day hospitalization [Reg. 38a-501-11(h)]** A LTC policy cannot condition benefits upon prior hospitalization or institutionalization.

On page 216, replace the heading of “9. Coordination of benefits [Regs. 38a-554-1 to 6]” with “9. Coordination of benefits [Secs. 38a-480-1 to 5; Regs. 38a-554-1 to 6]”.

On page 217, replace the content of “Q. Failure to Pay Accident and Health Claims” with the following:

- Q. Failure to Pay Accident and Health Claims [Sec. 38a-816(15)]** If an insurer fails to pay an accident and health claim within 45 days of receipt of the claimant’s proof of loss (unless a legitimate dispute exists), the insurer must pay interest at the rate of 15% per annum to the claimant, in addition to any other penalty provided by Connecticut law

Part II

Changes to Questions

On page 223, replace question no. 25 with the following:

25. Producer licenses renew every two years on
- A. the producer's birthday
 - B. February 1
 - C. the last day of the producer's birth month
 - D. March 1

On page 225, replace the stem of question no. 43 with the following:

43. An insurer will be assessed interest at a rate of 15% per year on an unpaid claim unless the claim is filed within....

Part III

Changes to Answers or Rationales

On page 168, replace the answer key for question no. 38 with the following:

- 38. D** Under a disability income policy purchased and paid for by an employer on a key employee, the latter being the recipient of the benefits, the premiums are tax deductible to the employer, but the employee must pay income tax on the benefits received.

On page 227, change the answer key for no. 26 from “B” to “C.”

On page 227, change the answer key for no. 49 from “B” to “A.”

Part IV

Corrections

There are no errata reported at this time.

To submit comments or suggestions, please send an email to errata@kaplan.com.



www.kaplanfinancial.com
1905 Palace Street, La Crosse, WI 54603
800-824-8742