LLQP Exam Handbook

Checked November 2026 · facts from official pages only · questions and explanations are our own

What the exam looks like

Item	Current rule	Checked
Format	Multiple choice, one best answer of four, marked on an answer sheet; 75 minutes per module.	2026–11–15
Questions and scoring	Life, Accident & Sickness, and Segregated Funds & Annuities: 35 questions each, scored out of 30. Ethics (common law): 25 questions, scored out of 20. Each module includes 5 unscored pilot questions.	2026–11–15
Pass mark	60% in each module.	2026–11–15
Reference material	Only the CISRO LLQP exam reference material, in electronic form: a tablet in Metro Vancouver and Prince George, a computer elsewhere. No course material or notes.	2026–11–15
Fees	$80 per module; $210 for all four modules on one day in Metro Vancouver; $80 to rewrite one module; about $80 + GST extra to the test centre in Cranbrook, Kelowna and Victoria.	2026–11–15
Eligibility review	Submit an LLQP Eligibility Verification in the portal first. The fees page says review takes up to 3 business days (the SEPT2025 examinee guide still says 1).	2026–11–15
12–month window	You must hold a licence within 12 months of your first passed module; modules outside the window must be rewritten. Course completion certification is valid for one year.	2026–11–15
Rewrites	No wait after the first three failed attempts; after the fourth, wait one year and retake the course. A January 2025 Council policy PDF still says 24 hours between attempts; the two official documents disagree.	2026–11–15
Results	By 4:30 p.m. PT, three business days after the exam in Metro Vancouver and five elsewhere.	2026–11–15
Curriculum weights	CISRO weights within each module: assessing needs 35%, analysing products 30%, implementing the recommendation 25%, in–force service 10% (Ethics: legal aspects 60%, agent rules 40%). Modules have no weights against each other; each must be passed on its own.	2026–11–15

Where the marks are

The LLQP is four separate module exams, 75 minutes each, each passed at 60%; modules carry no weight against each other. Inside each module, CISRO's weights decide where the marks are: assessing the client's needs is 35%, more than any single product, so the client–profile and needs–analysis chapter is P1 in every module.

Ch	Topic	Section	Priority	Mock

01	Why Life Insurance Is Needed: Risk of Death, Financial Impacts, and Four Risk Management Strategies	Life Insurance	P2 Hold steady	3
02	Term Life Insurance	Life Insurance	P1 Must score	2
03	Whole Life and Term–100: Dividends, Cash Value, and Non–Forfeiture Benefits	Life Insurance	P1 Must score	2
04	Universal Life Insurance: Unbundled Elements, YRT vs. LCOI, Exemption Test, and Common Missteps	Life Insurance	P1 Must score	2
05	Riders and Supplementary Benefits	Life Insurance	P2 Hold steady	1
06	Group Life Insurance	Life Insurance	P3 Skim	1
07	Taxation of Life Insurance and Tax Planning Strategies	Life Insurance	P2 Hold steady	2
08	Business Life Insurance: Key Person, Buy–Sell Agreements, and Corporate–Owned Policies	Life Insurance	P2 Hold steady	1
09	Application and Underwriting	Life Insurance	P1 Must score	3
10	Assessing the Client's Situation: Determining Life Insurance Needs (Income Replacement vs. Capital Needs Approach)	Life Insurance	P1 Must score	6
11	Recommending an Insurance Policy	Life Insurance	P1 Must score	4
12	Ongoing Policy Service	Life Insurance	P2 Hold steady	3
13	What Accident and Sickness Insurance Protects: Financial Goals and Four Risk Categories for Individuals, Families, and Businesses	Accident & Sickness	P2 Hold steady	4
14	Disability Insurance (DI): Income Replacement, Coordination of Group, Individual, and Government Benefits	Accident & Sickness	P1 Must score	3
15	Critical Illness & Long–Term Care Insurance	Accident & Sickness	P1 Must score	3
16	Extended Health, Dental, and Travel Insurance	Accident & Sickness	P2 Hold steady	2
17	Business Disability Insurance: BOE, Key Person Disability, and Disability Buyout	Accident & Sickness	P3 Skim	1
18	Client Profile: Income, Assets, Existing Coverage, and Gap Analysis	Accident & Sickness	P1 Must score	7
19	A&S Recommendation, Contract and Service: Statutory Conditions, Claims and Renewability	Accident & Sickness	P1 Must score	9

20	Group Benefit Plans: Eligibility, Rating, Co-ordination of Benefits, and ASO	Accident & Sickness	P3 Skim	1
21	Investment and Savings Basics: Compounding, Registered Accounts, and the FHSA Missing from the Exam Manual	Segregated Funds & Annuities	P2 Hold steady	3
22	Segregated Funds: Guarantees, Protection, and How They Really Differ from Mutual Funds	Segregated Funds & Annuities	P1 Must score	5
23	Annuities: Turning a Lump Sum into Lifetime Income, Annuity Classifications, and Prescribed Taxation	Segregated Funds & Annuities	P1 Must score	3
24	Investor Profile: KYC, Risk Tolerance, Risk Capacity, and Suitability, and Why It Carries 35% of This Module	Segregated Funds & Annuities	P1 Must score	7
25	Segregated Fund and Annuity Recommendation: From Profile to Product, Application, and Reason-Why Letter	Segregated Funds & Annuities	P1 Must score	7
26	Segregated Fund (IVIC) and Annuity Contracts: Clause-by-Clause Guarantees and Administration	Segregated Funds & Annuities	P2 Hold steady	4
27	Group Retirement and Investment Plans: DB vs. DC Responsibilities and Post-CPP Enhancement Planning	Segregated Funds & Annuities	P3 Skim	1
28	Legal Framework Governing Life Insurance: Which Law BC Actually Uses	Ethics & Professional Practice	P1 Must score	4
29	Insurance Policy Provisions	Ethics & Professional Practice	P1 Must score	4
30	Claims and Payment of Proceeds	Ethics & Professional Practice	P1 Must score	4
31	Bodies That Protect the Client	Ethics & Professional Practice	P2 Hold steady	3
32	Main Responsibilities of Life Insurance Agents	Ethics & Professional Practice	P1 Must score	5

The whole exam on one map



How to use this handbook

1. Start with the 32-question diagnostic on the site to find your red chapters.
2. Before reading each chapter, answer its starter questions on instinct, then check them as you read.
3. Each chapter is two sides of one sheet: front = how it is tested, traps, mind map; back = key points and self-test cues (cover the right two columns).
4. Do this chapter's questions in the question book; for misses, do the variants.
5. The night before, read only the final review sheet.

Chapter 1 · Why Life Insurance Is Needed: Risk of Death, Financial Impacts, and Four Risk Management Strategies

Life Insurance | P2 Hold steady | Why Life Insurance · 3 mock questions

Read with these questions: In a family with a single parent or a stay–at–home spouse, what major shortfall besides interrupted salary is commonly overlooked upon death?; When addressing the risk of death, which of the four strategies do a healthy lifestyle, using personal savings, and buying life insurance correspond to?; Canada has no estate tax, so why do individuals holding appreciated assets or corporate shares still face substantial tax bills at death?; Once retired with the mortgage paid off and children self–supporting, is a person completely free of financial impacts of death?

How it is tested

- Multi–dimensional impact identification questions: The question stem provides the comprehensive background of a family or business owner (such as a single parent, mortgage, non–registered appreciated assets, young children) and requires identifying which categories of financial impacts of death are triggered simultaneously, testing whether the candidate overlooks the loss of caregiver for a non–earning party or deemed disposition tax liabilities.
- Four risk management strategies matching questions: The question stem describes an action taken by a client (such as quitting smoking, setting aside existing savings for funeral expenses, or purchasing an insurance policy) or asks whether a specific strategy is feasible for the risk of death, testing the precise distinction and combined application of risk avoidance, risk reduction, risk retention, and risk transfer.
- Deemed disposition and tax awareness questions: Using scenarios where a client claims that because Canada has no estate tax, no tax is owed at death, or where a business owner transfers qualified small business corporation shares, testing the deemed disposition mechanism, the spousal rollover exception, and the rule that the Lifetime Capital Gains Exemption (LCGE) only partially offsets capital gains rather than fully eliminating tax.
- Dual–benchmark and numerical mechanics questions: Centering on the relationship between probability of death and life expectancy in mortality tables, as well as the exam standard and assessment rules for the CPP survivor's pension and lump–sum CPP death benefit, testing the concept of conditional expectation and avoiding blind application of maximum amounts.
- Practice process and life cycle matching questions: Describing a client's life stage (single, starting a family, career progression, approaching retirement) or an agent's practice workflow, testing that needs analysis must precede product recommendations, as well as how primary financial impacts change across life stages.

Traps (watch for the signal)

Category omission (counting lost salary while overlooking lost caregiving): The question stem features a stay–at–home spouse caring for young children or disabled relatives, or a single parent raising minor children alone.

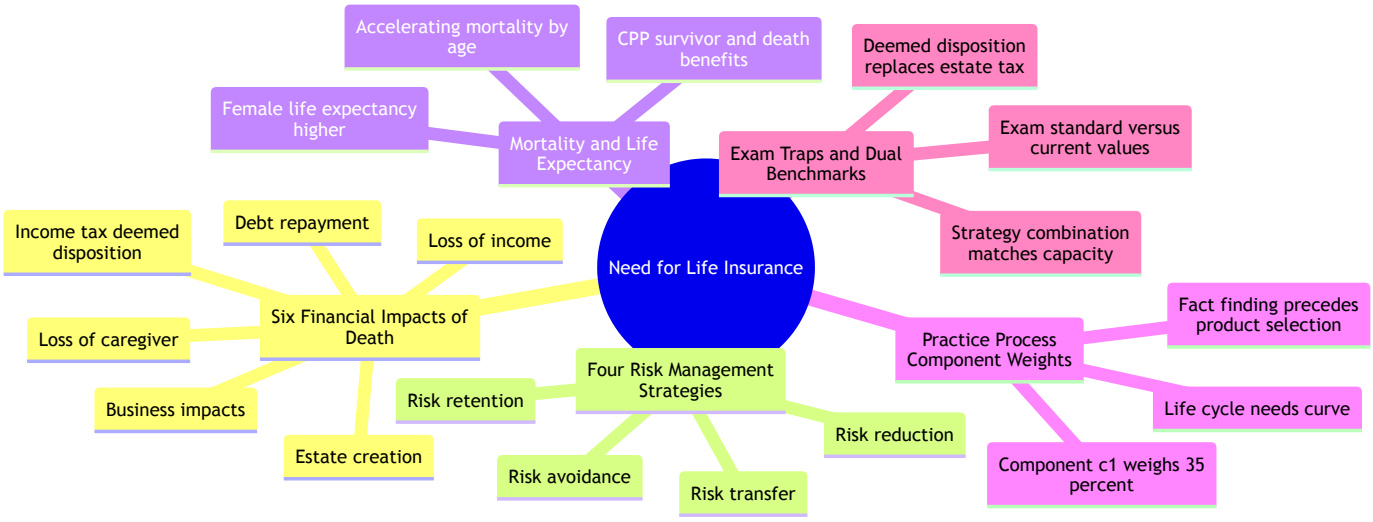
Concept confusion (equating no estate tax with no taxes at death): The question stem features a client holding an appreciated vacation cottage, non–registered investment portfolio, corporate shares, or large RRSP/RRIF balances, with adult children rather than a spouse named as heirs.

Mechanics confusion (treating unavoidability as inability to reduce or retain risk): The question stem mentions improving lifestyle habits, adding workplace safety measures, or a client possessing ample liquid assets to cover small final expenses.

Dual–benchmark blind application (assuming government benefits or exemptions automatically eliminate all liability): The question stem mentions expecting government benefits to fully cover all final expenses or assuming corporate shares can be transferred with zero cash for taxes because of the LCGE.

Reversal of nature and process (treating life insurance as an investment or pitching products before needs analysis): The question stem asks for the core function of life insurance, or asks for the agent's immediate next step after confirming that the client needs to transfer the risk of death.

Mind map


Need for Life Insurance
Mortality and Life Expectancy
Accelerating mortality by age
CPP survivor and death benefits
Female life expectancy higher
Exam Traps and Dual Benchmarks
Deemed disposition replaces estate tax
Exam standard versus current values
Strategy combination matches capacity
Six Financial Impacts of Death
Debt repayment
Loss of income
Income tax deemed disposition
Loss of caregiver
Business impacts
Estate creation
Four Risk Management Strategies
Risk retention
Risk avoidance
Risk transfer
Risk reduction
Practice Process Component Weights
Fact finding precedes product selection
Life cycle needs curve
Component c1 weighs 35 percent

Chapter 1Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Six financial impacts of death	financial impacts of death	Financial impacts of death fall into six categories: loss of income, loss of caregiver, debt repayment, income tax, estate creation, and business impacts. Needs analysis must examine and sum each category rather than choosing only one.
Independent quantification of loss of caregiver	loss of caregiver	When a family caregiver with no earned income or a single parent raising children dies, survivors must pay out of pocket to hire replacement childcare or caregiving services, which must be quantified as an independent financial shortfall in needs analysis.
Applicability of four risk management strategies to the risk of death	risk management strategies	The risk of death cannot be avoided (avoidance is inapplicable); health and safety measures reduce but cannot eliminate it; severe losses exceeding personal capacity must be transferred through life insurance, while affordable minor portions can be retained.
Difference between probability of death and life expectancy	probability of death and life expectancy	Probability of death is the percentage chance of dying within one year at a specific age and increases non-linearly with age. Life expectancy is the conditional average remaining years after reaching a specific age (at age 65, female exceeds male: exam standard 22.2 years vs 19.5 years; 2023 Statistics Canada data 22.3 years vs 19.7 years).
Dual benchmarks for CPP death benefit and survivor pension	CPP death benefit and survivor's pension	The basic lump-sum CPP death benefit is $2,500 (up to $5,000 under qualifying conditions from 2025 onward). The maximum monthly survivor pension under the 2022 exam standard is $674.79 (under 65) / $752.15 (65 and over), whereas the 2026 maximum is $803.54 / $904.59. Needs analysis must assess actual eligibility rather than blindly applying maximum amounts.
Deemed disposition and Lifetime Capital Gains Exemption	deemed disposition and LCGE	Canada has no federal or provincial estate tax, but death triggers a deemed disposition of capital property at fair market value for income tax purposes. Qualified small business corporation shares and qualified farm or fishing property may use the LCGE (2022 exam standard $913,630; 2026 ceiling $1,275,000) to offset part of the gain, with the remainder taxed before estate distribution.
CISRO competency component weighting and practice workflow sequence	CISRO competency component and needs analysis	Component c1 'assesses the client's needs and situation' holds the largest weight in the Life module at 35% (core calculations in ch10). After confirming that risk must be transferred, the agent must first conduct a fact-finding interview and needs analysis to quantify the shortfall before recommending products.
Evolution of life insurance needs across family life stages	life insurance needs across life stages	The single stage with no dependents has minimal financial impact; the family formation and mortgage repayment stage sees income and caregiving gaps peak; career progression and business ownership highlight estate creation and business impacts; in retirement, lost earned income fades, but estate creation and share deemed disposition taxes persist.
1972 tax reform and core positioning of life insurance	estate creation and risk transfer	The 1972 Canadian tax reform eliminated the federal estate tax and established capital gains taxation via deemed disposition at death, establishing life insurance estate creation as the primary mechanism to fund terminal tax and debt liabilities. The essence of life insurance remains risk transfer, not investment.

Self-test cues (Cornell left column)

1. Why must the evaluation of the risk of death look beyond just a lost salary, and what are the six categories of financial impacts of death?
2. When applying the four risk management strategies (avoidance, reduction, retention, transfer) to the risk of death, which strategy is completely inapplicable, and how do the other three work together?
3. Why does the probability of death increase with age, yet life expectancy at age 65 plus 65 exceeds life expectancy at birth, and how do the exam standard and current figures differ?
4. When a client says Canada has no estate tax so no tax is owed at death, how do you refute this using the post-1972 deemed disposition rules and the LCGE?
5. How is the highest-weighted Life module component c1 (35 percent) distributed, and what is the agent's standard next step after confirming that a client needs to transfer the risk of death?

Summary: Summarize in three sentences: which six financial impacts are triggered by death, why the core essence of life insurance is risk transfer rather than investment, and the connecting workflow from identifying risks to conducting needs analysis calculations in Chapter 10.

Chapter 2 · Term Life Insurance

Life Insurance | P1 Must score | Term Life · 2 mock questions

Read with these questions: If a convertible term policy held for three years is converted to permanent insurance, do the two-year incontestability and suicide exclusion clocks restart?; Given that ongoing premiums under original-age conversion are lower than under attained-age conversion, why is it not necessarily cheaper overall?; When medical tests reveal abnormalities requiring further investigation, should a client wait for a diagnosis before exercising conversion on a term policy?; If spouses shared a joint first-to-die term policy, can the non-policyholder spouse directly change the beneficiary to a new partner after divorce?

How it is tested

- Contractual rights distinction questions: Presenting scenarios where the life insured's health deteriorates or the policy is nearing expiry, testing whether candidates can distinguish between renewability (continuing term coverage at expiry without proof of insurability) and convertibility (exchanging for permanent coverage before a specified maximum age without proof of insurability) as two completely separate contractual rights.
- Legal consequences of conversion questions: Presenting claim or policy cancellation disputes after exercising conversion on a convertible term policy held for several years, testing that conversion represents the continuation of existing contractual rights rather than cancelling and reissuing—requiring no proof of insurability, and with the two-year clocks for the incontestability period and suicide exclusion clause running continuously from the original term policy issue date.
- Conversion and renewal pricing comparison questions: Comparing attained-age conversion with original-age conversion, or comparing renewability with guaranteed rates with re-entry term, testing whether candidates understand that original-age conversion requires paying the difference in premiums plus possible interest, and that re-entry term provides one-way protection for the policyholder.
- Coverage structure and debt liability matching questions: Combining remaining mortgage terms, child dependency periods, or co-borrower scenarios, testing the coverage and premium characteristics of level, decreasing, and increasing term insurance, as well as joint first-to-die coverage, along with the differences between lender mortgage insurance and individual term policies regarding beneficiaries and portability.
- Policy rights ownership and dual-benchmark boundary questions: Testing policy change rights ownership for joint first-to-die policies upon divorce or family changes (determined by policyholder status and subject to irrevocable beneficiary, collateral assignment, or court order restrictions), as well as distinguishing between exam-standard fixed terms (1, 5, 10, 20 years) and

Traps (watch for the signal)

Confusing renewability with convertibility: The question stem mentions 'at expiry' or 'continue temporary coverage' pointing to renewability; mentions 'permanent coverage', 'whole life', or 'Term 100 before a maximum age' pointing to convertibility.

Assuming conversion resets the two-year clocks: The question stem notes that the original term policy has been in force for three or five years, or remains within the two-year window, and asks whether the insurer can deny a claim for undisclosed medical abnormalities at conversion, or when the suicide exclusion period starts.

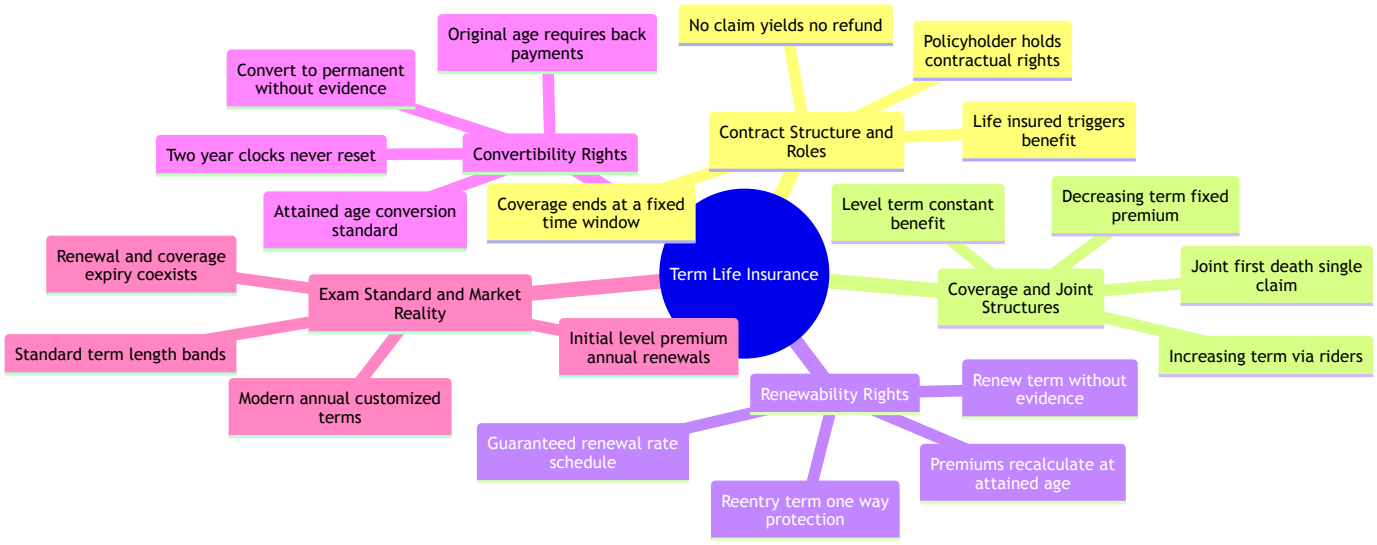
Blindly assuming original-age conversion is always more cost-effective: The question stem compares attained-age conversion with original-age or retroactive conversion, and options include 'always results in lower total outlay' or 'requires no lump-sum adjustment'.

Assuming decreasing term premiums decrease alongside coverage: The question stem features a decreasing term policy covering a mortgage or compares lender mortgage insurance with an individual term policy, asking about premium trends, beneficiary rights, or policy ownership.

Confusing life insured status with policyholder control: The question stem features a joint first-to-die policy alongside divorce, separation, or changing the beneficiary, and indicates the policy was originally taken out by one party alone as policyholder.

modern annually customized terms, along with specific contractual maximum conversion ages.

Mind map



Chapter 2Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Core payout condition of term life insurance	Term life insurance / Death benefit	A death benefit is paid only if the life insured dies within the specified term; if the term expires without a claim, the contract terminates with no refund or cash value whatsoever.
Separation of rights between policyholder and life insured	Policyholder vs. Life insured	The policyholder and the life insured are not necessarily the same person; exercising rights to alter, surrender, or assign the policy belongs exclusively to the policyholder, subject to restrictions from irrevocable beneficiaries, collateral assignments, or court orders.
Payout mechanics of joint first-to-die term insurance	Joint first-to-die	A joint first-to-die policy covers two lives under a single coverage amount and pays out once upon the first death of either insured; because the insurer only assumes the risk of a single payout, the premium is lower than purchasing two separate individual policies.
Independence of renewability and convertibility	Renewability vs. Convertibility	Renewability allows continuing term insurance upon expiry without proof of insurability at attained-age rates, whereas convertibility allows exchanging for permanent insurance before a contractual maximum age without proof of insurability; they are completely independent contractual rights.
Continuation of two-year statutory clocks upon conversion	Incontestability period & Suicide exclusion clause	Exercising convertibility requires no proof of insurability, and the two-year statutory clocks for the incontestability period and suicide exclusion clause continue running from the original term policy issue date rather than resetting upon conversion.
Renewable with guaranteed rates versus re-entry term	Renewable with guaranteed rates & Re-entry term	Policies renewable with guaranteed rates lock in a contractual renewal schedule at issue, whereas re-entry term allows policyholders in good health at expiry to qualify for lower preferred rates, while retaining the right to renew at guaranteed rates if they fail or decline underwriting.
Pricing differences between attained-age and original-age conversion	Attained-age conversion vs. Original-age conversion	Attained-age conversion prices permanent insurance using the age at conversion and represents the standard market design; original-age or retroactive conversion prices permanent coverage at the original issue age, but charges higher initial term premiums and requires a lump-sum payment of back premium or cash value differences plus possible interest upon conversion.
Three coverage structures and distinctions from lender mortgage insurance	Level / Decreasing / Increasing term	In decreasing term insurance, coverage decreases over time while premiums typically remain level throughout; individual term insurance allows policyholders to designate beneficiaries and remains fully portable, whereas lender mortgage insurance pays directly to the lender and is non-portable.
Dual-benchmark rules for term lengths and maximum conversion ages	Standard term lengths & Maximum conversion age	Exam conventions reference traditional industry bands such as 1, 5, 10, or 20 years or to age 60 and calculate conversion limits strictly from figures given in the scenario, whereas modern market practice offers annual custom terms (such as 17 years) and carrier-specific conversion cutoffs (such as within 6 months of age 69, or before age 70 or 71).

Self-test cues (Cornell left column)

1. Why are renewability and convertibility two completely separate contractual rights?
2. When exercising convertibility, how are the two-year clocks calculated for the incontestability period and suicide exclusion clause?
3. Original-age conversion yields lower ongoing premiums after conversion, so why is it not necessarily more cost-effective than attained-age conversion?
4. The death benefit of decreasing term insurance decreases annually, so how does its premium change over the contract term?
5. When handling a joint first-to-die policy after a divorce, why cannot both parties be presumed to hold policy change rights?

Summary: In three sentences, summarize the two guaranteed insurability switches of term life insurance (renewability and convertibility), the two fundamental rules of conversion (no proof of insurability and two-year clocks continuing from original issue date), and the three cost components of original-age conversion.

Chapter 3 · Whole Life and Term–100: Dividends, Cash Value, and Non–Forfeiture Benefits

Life Insurance | P1 Must score | Whole Life & T–100 · 2 mock questions

Read with these questions: If a client's health deteriorates but they want to increase lifetime coverage, which dividend option allows them to do so without medical underwriting?; If a policyholder wants to stop paying premiums permanently while keeping the full original face amount, which non–forfeiture option should they choose?; Why can a premium offset illustration never be treated as a contractual guarantee, and what happens when the dividend scale falls?; If a client solely wants to leave a fixed amount to charity upon death and needs no living cash access, which product is most cost–effective?

How it is tested

- Dividend mechanics and dividend option distinction questions: Presenting scenarios where a client's health deteriorates but they wish to increase lifetime coverage, or mistakenly believe dividends are contractually promised fixed returns, testing the board discretion nature of participating (par) policies and the core advantage of purchasing paid–up additions (PUA) without medical underwriting.
- Cash surrender value and policy loan calculation questions: Providing a policy's cash surrender value (CSV), the maximum loan percentage (the standard exam benchmark commonly cites 90%), and outstanding loan principal and interest, testing the net amount an assignee or beneficiary actually receives upon surrender or the death of the life insured.
- Premium cessation and four non–forfeiture option scenario questions: Describing different policyholder objectives after stopping premium payments (such as wanting to permanently stop paying while maintaining a reduced lifetime benefit, or wanting to keep the full original face amount for a limited period), testing the precise matching among cash surrender, automatic premium loan (APL), reduced paid–up insurance, and extended term insurance.
- Product positioning comparison questions between Term–100 and whole life insurance: Presenting client cases involving estate tax coverage, fixed–amount charitable donations, or emergency living cash access needs, testing Term–100 (T–100) features including level cost of insurance (LCOI), the typical absence of cash surrender value, and the lack of non–forfeiture benefit buffers upon lapse.
- Premium offset and dual–column disclosure compliance questions: Reconstructing dispute scenarios where falling interest rates push back projected premium–stop years, testing the non–guaranteed nature of vanishing premiums and the compliance requirement that policy illustrations

Traps (watch for the signal)

Confusing contractual participation rights with dividend amounts: The question stem or options include terms like guaranteed dividend, fixed annual return, or equate the dividend scale interest rate with a deposit rate on an accumulate–at–interest account.

Mixing up reduced paid–up insurance and extended term insurance: The question stem emphasizes whether the client stopping premiums wishes to maintain the original face amount (extended term) or maintain permanent lifetime coverage (reduced paid–up).

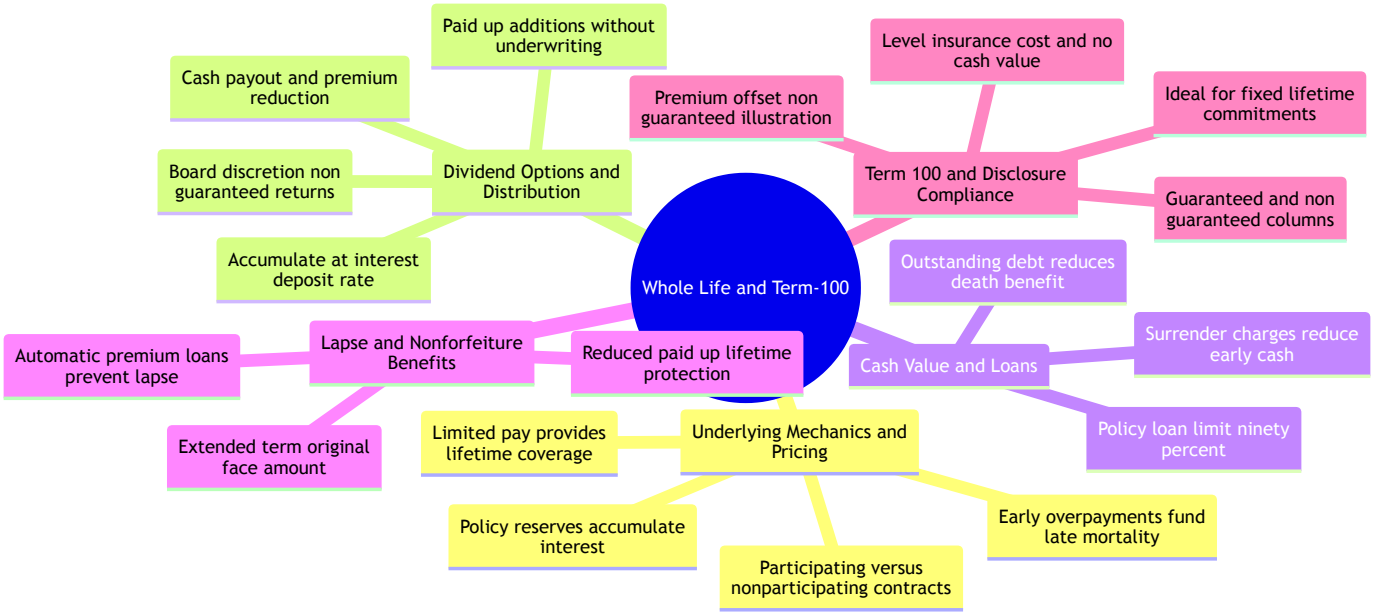
Treating paid–up additions as an underwritten rider: The question stem mentions that the life insured's health has deteriorated, yet they still wish to use policy dividends to increase permanent coverage.

Applying whole life lapse buffers to Term–100: The question stem identifies the policy as Term–100 (T–100) and states the policyholder missed the premium beyond the grace period, asking if policy value can advance the premium or convert to paid–up coverage.

Treating premium offset illustrations as contractual promises: The question stem mentions premium offset or vanishing premium, noting that following declines in market interest rates and dividend scales, the insurer requires ongoing premium payments.

and annual statements display guaranteed and non–guaranteed columns side by side.

Mind map



Chapter 3Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Policy reserves and level premium mechanics	policy reserve	Whole life insurance builds a policy reserve by collecting more premium than needed in early years, compounding with interest to subsidize surging mortality costs in old age, thereby keeping lifetime premiums level and fixed.
Rights and discretionary boundaries of participating policies	participating (par) policy	Participating in surplus distributions is a contractual right, but whether a dividend is declared and its amount are at the sole discretion of the insurer's board of directors and are not guaranteed; for the same coverage, non-participating premiums are typically lower.
Structure of limited payment whole life insurance	limited payment whole life	Limited-payment policies (such as 10-pay or 20-pay) shorten the premium-paying period to eliminate the risk of outliving one's ability to pay, while coverage remains for life, at the cost of significantly higher periodic premiums than life-pay policies.
Paid-up additions (PUA) mechanics	paid-up additions (PUA)	Using declared annual dividends as single premiums to purchase small amounts of paid-up permanent insurance without medical underwriting permanently increases both the total death benefit and future cash values; the exam benchmark states that over 90% of participating policies select this option.
Distinction between dividend scale interest rate and accumulate-at-interest deposit rate	dividend scale interest rate	The dividend scale interest rate is merely an internal actuarial assumption used to calculate dividend scales; if declared dividends are left to accumulate at interest, a separate deposit rate set by the insurer applies, which is typically significantly lower than the dividend scale rate.
Cash surrender value and policy loan limits	cash surrender value (CSV) & policy loan	Early cash surrender value (CSV) often reflects $0 due to surrender charges; once accumulated, policyholders can borrow against it (the exam benchmark commonly cites 90% of CSV as the maximum loan limit), and unpaid principal plus interest are deducted from both surrender proceeds and death benefits.
Distinguishing the four non-forfeiture benefit options	non-forfeiture benefits	When sufficient CSV exists, an APL automatically advances premiums to prevent policy lapse; surrendering pays out the net CSV directly; reduced paid-up insurance uses CSV to buy reduced lifetime coverage; extended term insurance uses CSV to buy term coverage for the full original face amount for a limited duration.
Term-100 pricing and lapse consequences	Term-100 (T-100)	Priced using a level cost of insurance with premiums capped at age 100 for lifetime coverage, Term-100 typically builds no CSV or non-forfeiture benefits, lapsing outright if premiums remain unpaid past the grace period; it suits fixed-amount permanent commitments needing no cash-value flexibility.
Premium offset risks and dual-column disclosure rules	premium offset / vanishing premium	Premium offset relies on non-guaranteed dividend assumptions, meaning declining dividend scales will postpone the projected premium-stop year; regulators require policy illustrations and annual statements to present guaranteed and non-guaranteed columns side by side.
Modal factors across payment frequencies and product types	modal factor	Term and whole life policies apply a modal factor for non-annual payments (the exam benchmark notes annualized monthly premiums total roughly 6% more than annual premiums), whereas universal life (UL) typically has no modal factor.

Self-test cues (Cornell left column)

1. Why does whole life insurance collect higher premiums at younger ages, and what is the relationship between policy reserves and cash surrender value?
2. What do contractual participation rights and board discretion mean in a participating policy, and does the dividend scale interest rate equal a client deposit return?
3. What are the four core dividend options, and why is purchasing paid-up additions (PUA) best suited for a client whose health has deteriorated?
4. When premium payments stop, what core objectives do automatic premium loans (APL), reduced paid-up insurance, and extended term insurance address?
5. What fundamental differences exist between Term-100 and whole life regarding cash value, premium levels, and lapse consequences, and what scenarios fit each?

Summary: In three sentences, summarize how whole life insurance derives cash values, dividends, and non-forfeiture options from early policy reserves, and contrast this with Term-100 sacrificing cash value to provide low-cost permanent coverage.

Chapter 4 · Universal Life Insurance: Unbundled Elements, YRT vs. LCOI, Exemption Test, and Common Missteps

Life Insurance | P1 Must score | Universal Life · 2 mock questions

Read with these questions: Which combination of client actions is most likely to deplete a universal life account value and cause a policy lapse?; Why must the policy generation be verified before applying for changes on a grandfathered policy issued on or before December 31, 2016?; For a client intending lifetime holding with a fixed budget, is YRT or LCOI the safer choice?; Which borrowing route accesses policy cash value without triggering an immediate tax disposition?; If universal life premiums are switched to monthly payments, does the annualized total premium increase due to a modal factor?

How it is tested

- Unbundled three elements and virtuous circle deduction questions: Presenting premium deposits, account value fluctuations, and death benefit options, testing the sequential deduction order and causal chain among premium tax, cost of insurance (COI), net amount at risk (NAAR), and the accumulating fund.
- YRT versus LCOI cost curve matching questions: Providing a client's holding horizon (such as short-to-medium term of 10 to 15 years or lifetime holding), budget, and cash value accumulation goals, testing whether to recommend yearly renewable term (YRT) or level cost of insurance (LCOI), as well as the mechanics of policy depletion caused by long-term minimum funding under YRT.
- Level versus level plus account value comparison questions: Comparing the beneficiary's net payout with monthly deduction amounts, testing whether the net amount at risk (NAAR) decreases as account value grows under different death benefit options, and identifying under which option the virtuous circle takes effect.
- Exemption test and existing policy change risk questions: Setting scenarios where a client makes excess deposits or requests a face amount increase, conversion, or life insured change on a grandfathered policy issued on or before December 31, 2016, testing maximum funding limits, exemption test consequences, and the risk of policy generation (G1/G2/G3) demotion after January 1, 2017.
- Accumulating fund six rights and financing comparison questions: Presenting scenarios where a client requires emergency liquidity or plans retirement cash flow, distinguishing among partial withdrawals, premium offset, policy loans (50% to 90% limit), collateral assignment, and leveraging regarding tax disposition, death benefit deductions, and lender recourse.

Traps (watch for the signal)

Modal factor premium surcharge assumption trap: The question stem discusses the difference in annualized total premiums between monthly, quarterly, or semi-annual payments and annual payments in universal life (UL), or asks to calculate a modal surcharge.

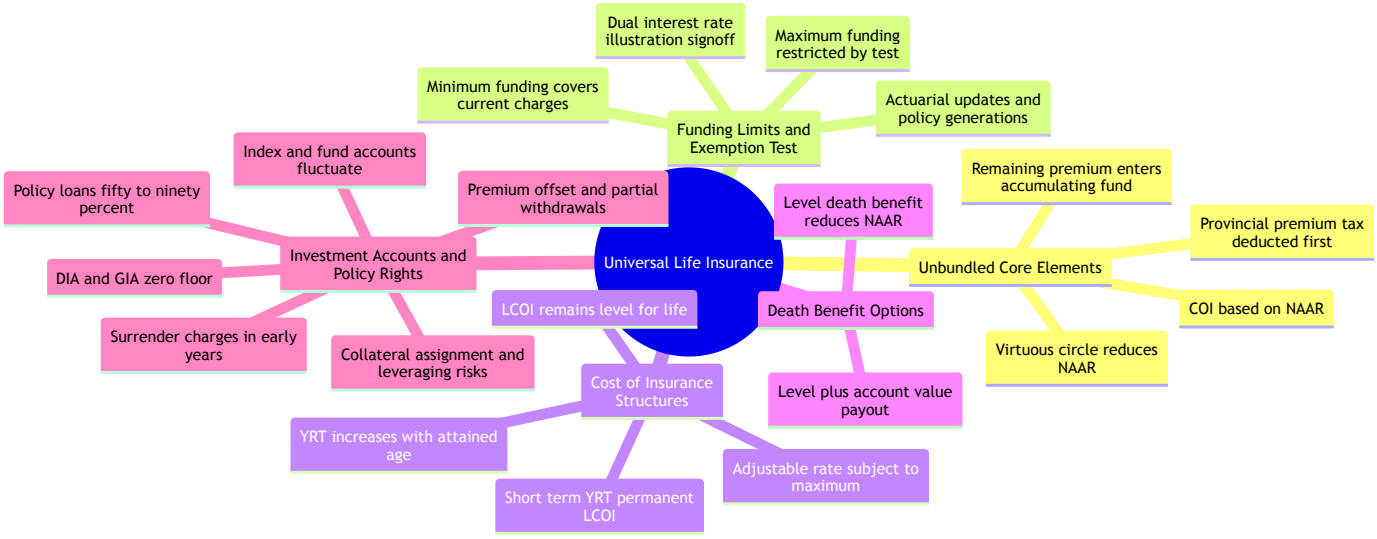
Illusion of low initial YRT pricing: The question stem simultaneously mentions intending to hold the policy for life or into old age, selecting a YRT cost structure, and paying only minimum funding over the long term.

Inverting NAAR and death benefit options: The question stem specifies the death benefit option as level death benefit plus account value and asks about the impact of account growth on current COI charges or NAAR.

Assuming face amount increases for existing clients require no underwriting: The question stem mentions an existing policyholder applying to increase coverage due to family or debt changes, or making major changes to a policy issued on or before December 31, 2016.

Confusing leveraging with collateral assignment: The question stem involves accessing accumulating fund values for cash flow, contrasting the tax treatment, interest repayment mechanics, and forced liquidation risks between insurer policy loans and third-party bank collateral assignment loans.

Mind map


Universal Life Insurance
Funding Limits and Exemption Test
Dual interest rate illustration signoff
Maximum funding restricted by test
Minimum funding covers current charges
Actuarial updates and policy generations
Investment Accounts and Policy Rights
Index and fund accounts fluctuate
Policy loans fifty to ninety percent
Premium offset and partial withdrawals
DIA and GIA zero floor
Surrender charges in early years
Collateral assignment and leveraging risks
Unbundled Core Elements
Remaining premium enters accumulating fund
Provincial premium tax deducted first
COI based on NAAR
Virtuous circle reduces NAAR
Death Benefit Options
Level death benefit reduces NAAR
Level plus account value payout
Cost of Insurance Structures
LCOI remains level for life
YRT increases with attained age
Short term YRT permanent LCOI
Adjustable rate subject to maximum

Chapter 4Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Unbundled elements and premium deposit sequence	unbundling / accumulating fund	When a premium is deposited, provincial premium tax is deducted from the gross premium first, the remainder enters the accumulating fund, monthly or annual cost of insurance (COI) and administration fees are deducted from it, and the remaining balance compounds in the selected investment accounts.
Net amount at risk and the virtuous circle	net amount at risk (NAAR)	Net amount at risk (NAAR) equals the death benefit minus the account value and is the sole basis for calculating mortality deductions (COI); under a level death benefit, a higher account value results in a lower NAAR and reduced deductions.
Minimum and maximum funding boundaries	minimally funded / maximum funded	Minimum funding covers only current costs and charges (often designed to age 100 for exam purposes but not guaranteed for life); maximum funding is capped by the exemption test to prevent the policy from functioning solely as a tax shelter.
Exemption test and 2017 generation watershed	exemption test / G1/G2/G3 policy classification	On each policy anniversary, actual accumulating fund values are compared against a hypothetical benchmark policy; after the major actuarial update on January 1, 2017, increasing coverage, converting, or changing the life insured on pre-2017 policies may trigger generation demotion.
Dual interest rate assumptions for illustrations	policy illustration	Universal life policy illustrations must present at least two investment return assumptions (the current rate and a significantly lower rate), and the policyholder must sign acknowledging that neither set of figures is guaranteed.
YRT and LCOI pricing and conversion rules	yearly renewable term costing (YRT) / level cost of insurance (LCOI)	YRT is priced on attained age, starting low and escalating steeply later, making it suitable for 10 to 15 year horizons; LCOI is actuarially leveled at issue and stays fixed for life, fitting permanent horizons; some contracts permit converting YRT to LCOI, but converting back is generally prohibited.
Level versus level plus account value benefits	level death benefit / level death benefit plus account value	Under a level death benefit, the beneficiary receives only the face amount while account growth shrinks NAAR to save deductions; under level plus account value, the beneficiary receives the face amount plus the entire account value, meaning NAAR remains constant and deductions are higher.
Three investment account types, risks, and floors	daily interest account (DIA) / guaranteed investment account (GIA)	Daily interest accounts (DIA) and guaranteed investment accounts (GIA) typically have a 0% floor, whereas index or fund linked accounts do not hold underlying fund units and can experience negative returns, which accelerates account depletion when combined with minimum funding.
Six accumulating fund rights and surrender charges	surrender charge / premium offset / policy loan / collateral assignment / leveraging	The policyholder holds six rights: surrender (surrender charges apply in the first 5 to 10 years, often based on multiples of LCOI and capped at the account value), partial withdrawals, premium offset, policy loans (borrowing 50% to 90% of cash value), collateral assignment (without triggering disposition), and leveraging.
Absence of modal factor in universal life	modal factor	Unlike term and whole life insurance where monthly annualized premiums are higher (commonly around 6%), universal life has no modal factor, meaning monthly, quarterly, semi-annual, and annual payment schedules produce the identical annual total.

Self-test cues (Cornell left column)

1. When a premium is deposited into a universal life policy, which items are deducted before funds enter the investment account to compound?
2. Why does a level death benefit trigger a virtuous circle that reduces deductions, whereas level plus account value does not?
3. How do YRT and LCOI differ in cost performance over the first 10 to 15 years versus a lifetime horizon, and what are the conversion restrictions?
4. What triggers cause a universal life account value to become insufficient and slide toward lapse, and why do illustrations require two interest rate assumptions?
5. What are the differences in tax disposition and recourse risk among taking a direct policy loan, pledging the policy via collateral assignment, and policy leveraging?

Summary: In three sentences, summarize how, after unbundling the three elements in universal life insurance, the policyholder balances insurance costs, tax-sheltered growth, and lapse risk by selecting the cost structure (YRT or LCOI), death benefit option, and funding level.

Chapter 5 · Riders and Supplementary Benefits

Life Insurance | P2 Hold steady | Riders · 1 mock questions

Read with these questions: Does receiving a dread disease (DD) benefit or terminal illness (TI) benefit reduce the final death benefit?; What triggers a GIB addition without medical evidence, and are premiums calculated at the original or attained age?; When combining permanent needs and a 10–year mortgage under one policy, does the rider remain in force if the base policy is surrendered?; When parents insure a child or spouse and pay premiums, what claim denial results from selecting the wrong waiver provision?

How it is tested

- Calculating and distinguishing the impact of living benefits on the death benefit: Given a client's policy face amount and an advance limit for a terminal illness (TI) or dread disease (DD) benefit (such as 50% or up to $50,000), test that an accelerated death benefit acts as an advance that reduces the ultimate death benefit dollar–for–dollar, and contrast this with the separate, additional payout of a stand–alone critical illness (CI) insurance policy.
- Selecting waiver of premium benefits when the policyholder and life insured are different: In scenarios where parents purchase coverage for minor children or one spouse purchases coverage and pays premiums for the other, test whether the candidate can distinguish between a standard waiver of premium for total disability (which covers only disability of the life insured) and a parent or payor waiver benefit (which covers the policyholder's death or total disability).
- Structuring combinations of temporary and permanent needs: Given a scenario where a client has both lifelong tax liabilities and a 10–year debt obligation, test the rationale of combining a whole life base policy with a term insurance rider (saving duplicate underwriting and a $50 to $100 annual policy fee), as well as the legal consequences for dependent riders and paid–up additions (PUA) if the base policy lapses or is surrendered.
- Application of anti–selection protection mechanisms: Focus on clients with deteriorating health or who have become effectively uninsurable (such as an impaired child reaching a certain age or young policyholders), testing exercise rules for the child rider conversion privilege (converting to permanent insurance before expiry without medical evidence, up to a 5–fold increase) and guaranteed insurability benefit (GIB, exercising on fixed policy anniversaries without evidence of insurability at attained–age rates).
- Claim boundaries and needs analysis pitfalls of the accidental death (AD) rider: Through cases where a client dies of illness, suicide, or beyond the 1–year post–accident limit, or attempts to use double indemnity under

Traps (watch for the signal)

Treating Riders as Standalone Policies (Category Mismatch): The question stem mentions base policy lapse, expiry, or full surrender, and asks whether attached riders or supplemental paid–up coverage can be maintained.

Confusing Advances with Additional Payouts (Product Confusion): The question stem asks how the final death benefit received by beneficiaries changes after living benefits are paid, or compares an attached dread disease (DD) benefit with stand–alone critical illness (CI) insurance.

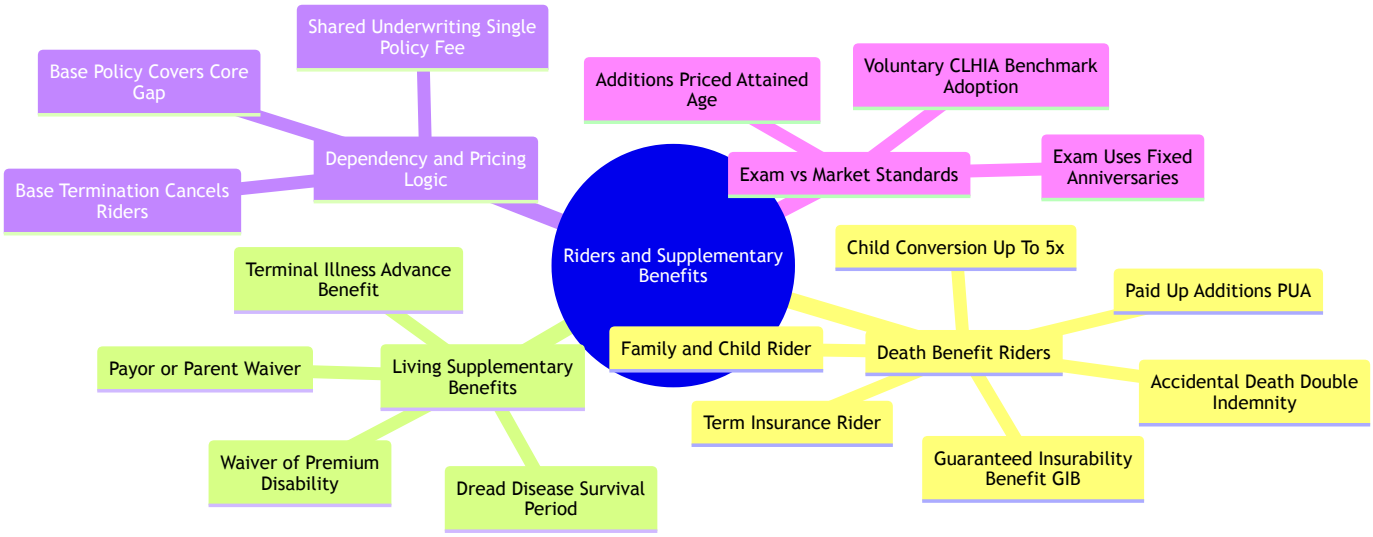
Mismatched Waiver Insured Parties (Provision Mismatch): The question stem presents parents insuring minor children or one spouse insuring the other and paying premiums, asking how to keep the policy in force if the payor dies or becomes totally disabled.

Misinterpreting GIB as Free or Anytime Coverage (Terminology and Dual–Standard Misreading): The question stem asks about premium pricing basis when exercising GIB, whether evidence of insurability is required, or when standard GIB option dates occur on the exam.

Relying on Accidental Double Indemnity for Core Coverage (Scope Inflation and Generalization): The question stem gives a client's fixed family debt or survivor living expense shortfall and proposes using low–cost AD riders to bring total payout up to the target amount.

an AD rider to fill a core family coverage gap, test policy exclusions and the principle that survivors' financial needs do not change based on the cause of death.

Mind map



Chapter 5Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Classification of Riders and Supplementary Benefits	riders and supplementary benefits	Under exam conventions, additional benefits paid after death are categorized as riders, while living triggers such as advances, separate payouts, or premium waivers are classified as supplementary benefits; however, in practice each contract's specific trigger provisions must be verified.
Bundled Pricing Advantages and Dependency Limitations	term insurance rider / paid-up additions (PUA) rider	Riders are less expensive than stand-alone policies because they share a single underwriting assessment and one annual policy fee (typically $50 to $100); however, they are dependent on the base policy, meaning riders terminate and PUA cash values are settled together upon base policy lapse or full surrender.
Claim Boundaries for Accidental Death and Dismemberment	accidental death (AD) rider / accidental dismemberment benefit	An AD rider pays an additional benefit (typically double indemnity) only if death is accidental and occurs within a stipulated timeframe following the accident (commonly 1 year), excluding suicide, self-inflicted injury, war, and criminal acts; AD&D additionally pays living benefits for loss of limbs or function according to a schedule of losses.
Advance and Deduction Mechanism of Accelerated Death Benefits	accelerated death benefit: terminal illness (TI) and dread disease (DD)	Terminal illness (TI, commonly capped at 25% to 75% of face value or 50% up to $50,000) and dread disease (DD, requiring survival past a typical 30-day waiting period) are advances that reduce the ultimate death benefit dollar-for-dollar, whereas stand-alone critical illness (CI) insurance does not deduct from the life insurance death benefit.
Automatic Coverage and Conversion Privilege of Child Riders	family/child coverage rider and converting child coverage rider	A child rider charges a flat premium per unit regardless of the number of children, automatically covering newborns once they reach a specified age (commonly 15 days, with no benefit if death occurs within the first 2 weeks) up to age 21 or 25, and can be converted before expiry without medical evidence into an individual permanent policy for up to 5 times the rider face amount.
Exercise Triggers and Premium Pricing for Guaranteed Insurability Benefit	guaranteed insurability benefit (GIB)	Under exam conventions, GIB is exercised on fixed policy anniversaries (such as the 5th or 10th anniversary) subject to single and cumulative limits (some modern contracts also allow exercise within 31 days of graduation, marriage, birth, or adoption), requiring no medical evidence but pricing new coverage at the insured's attained age.
Critical Illness Benchmark Definitions and Inter-Company Differences	CLHIA CI Benchmark Definitions / Big 4	The exam summarizes common critical illness coverage thresholds through the Big 4 (heart attack, stroke, coronary artery bypass surgery, and life-threatening cancer, while some insurers cover 25 or more conditions); although the industry has the CLHIA 2024 Final benchmark definitions, their adoption by insurers is voluntary and wording must be verified in each specific contract.
Core Shortfall Coverage Principle and Third-Party Underwriting	value of coverage and underwriting of riders	A family's core coverage shortfall must be fully covered by the base insurance policy rather than supplemented with riders; if a term insurance rider is attached to cover a spouse or another third party, that individual must undergo separate underwriting.
Distinguishing Total Disability Waiver from Parent or Payor Waiver	waiver of premium for total disability vs. parent/payor waiver benefit	A standard waiver of premium for total disability waives premiums after the life insured satisfies the waiting period while dividends and cash values continue to accumulate; when the policyholder is not the life insured, a parent or payor waiver benefit (requiring underwriting of the payor) must be added to waive premiums upon the payor's death or total disability.

Self-test cues (Cornell left column)

1. Why are riders generally less expensive than buying stand-alone policies, and what is the primary trade-off the client makes?
2. What is the fundamental difference in how accelerated death benefits (TI and DD) versus stand-alone critical illness (CI) insurance affect the final death benefit?
3. What key figures and rules frequently tested on exams apply to child riders regarding newborn coverage, pricing structure, and pre-expiry conversion privileges?

4. How do option exercise triggers for the guaranteed insurability benefit (GIB) differ between exam conventions and modern contracts, and what age determines the new premium rate?
5. When the policyholder and the life insured are different persons, whose risk is covered by a standard waiver of premium for total disability versus a parent or payor waiver benefit?

Summary: In three sentences, summarize: how to match appropriate riders based on a client's core death benefit gap versus temporary or living need gaps, whether the policyholder and life insured are the same person, and future health insurability risks, while explaining the boundary between exam conventions and actual contract verification.

Chapter 6 · Group Life Insurance

Life Insurance P3 Skim Group Life · 1 mock questions

Read with these questions: When an employer and employee split group life insurance premiums, which portion is a taxable benefit and is the death benefit taxable?; When a BC employee leaves employment with original coverage exceeding $200,000, what is the maximum amount they can convert without medical evidence within 31 days?; If a new employee completes a 3-month probationary period but is absent due to illness that day, can their coverage take effect?; How should the conversion privilege and any excess coverage gap be handled for an employee planning to retire on their 65th birthday?

How it is tested

- Premium and death benefit tax determination questions: Presenting employer and employee premium split percentages and salary-multiple coverage amounts, testing which portion constitutes a taxable benefit in the current year, which portion is not deductible, and whether the death benefit principal is tax-free, specifically checking whether candidates confuse the rules with group disability insurance.
- Conversion privilege calculation and condition questions upon termination or plan end: Combining employee age (before versus at age 65), original coverage, the non-Quebec $200,000 non-medical conversion cap, and the 31-day window to apply and pay the first premium, testing how much individual life coverage an employee can convert without evidence of insurability upon leaving employment.
- Three-party contractual relationship and statutory inspection right scenario questions: Presenting employer adjustments or terminations of a membership class, insurer replacements, or disputes arising from an employee requesting policy terms, testing the distinction between the master contract and benefit booklet as well as the right to inspect and copy the master policy under the BC Insurance Act.
- Eligibility and adverse selection control mechanism questions: Setting scenarios where a new employee is within the probationary period, fails to satisfy the actively-at-work requirement on the effective date, or misses the 60-day limited window before applying for optional additional coverage, testing whether coverage takes effect and whether medical underwriting is required.
- Ancillary coverage schedule reading and concept distinction questions: Placing flat family rates for dependant life coverage, termination conditions for monthly survivor income benefits (age 65, remarriage, or death), and dependant AD&D schedule percentages (50% versus 40% / 15%) into family scenarios for testing.

Traps (watch for the signal)

Inverting tax treatment across insurance lines: The question stem presents an employer group life premium contribution ratio (such as 70% / 30% or 100% employer-paid) and asks about the employee's current-year T4 taxable benefit or the beneficiary's death benefit tax consequences.

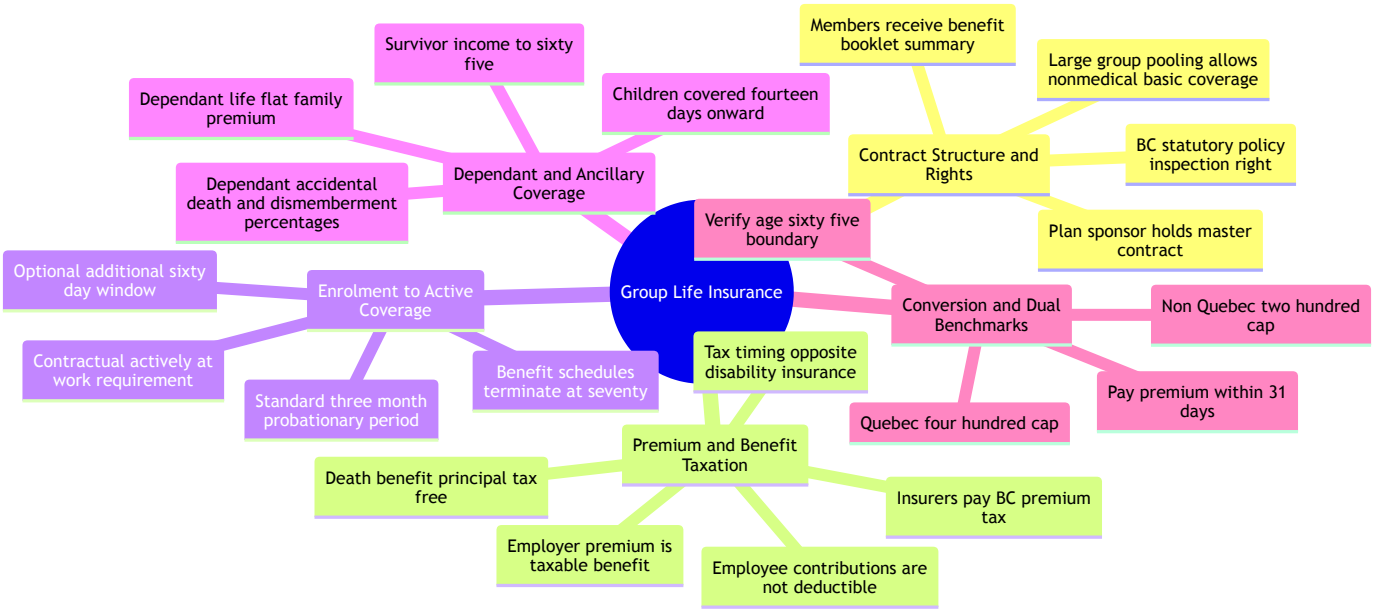
Treating the conversion cap as a fixed coverage amount or missing payment conditions: The question stem provides an employee's termination date, original coverage amount (above or below $200,000), and age, asking for the conversion privilege maximum amount without evidence of insurability or the required completion actions by the deadline.

Confusing master policy inspection rights with master contract boundaries: The question stem presents inconsistencies between the benefit booklet and master contract terms, claim disputes, or an employer modifying membership classes, asking who holds the master contract and whether a member can request a copy of the master policy from the insurer.

Over-presuming non-underwritten status for optional coverage and actively-at-work requirements: The question stem involves a new employee being absent from work on the day their 3-month probationary period ends, or an employee wanting to purchase optional coverage years after joining due to health changes.

Confusing dependant life rating with survivor income benefit concepts: The question stem involves a multi-child family enrolling in flat family rate dependant life coverage, the effect of spousal remarriage on monthly survivor income benefits, or switching spousal AD&D percentages between scenarios with and without children (50% versus 40% / 15%).

Mind map


Group Life Insurance
Dependant and Ancillary Coverage
Survivor income to sixty five
Dependant life flat family premium
Children covered fourteen days onward
Dependant accidental death and dismemberment percentages
Contract Structure and Rights
Members receive benefit booklet summary
Large group pooling allows nonmedical basic coverage
BC statutory policy inspection right
Plan sponsor holds master contract
Verify age sixty five boundary
Conversion and Dual Benchmarks
Non Quebec two hundred cap
Pay premium within 31 days
Quebec four hundred cap
Enrolment to Active Coverage
Optional additional sixty day window
Contractual actively at work requirement
Standard three month probationary period
Benefit schedules terminate at seventy
Tax timing opposite disability insurance
Premium and Benefit Taxation
Death benefit principal tax free
Insurers pay BC premium tax
Employer premium is taxable benefit
Employee contributions are not deductible

Chapter 6Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Group master policyholder and BC statutory inspection right	plan sponsor / master contract / benefit booklet	The employer or association acts as the plan sponsor entering into the master contract with the insurer, and members typically receive only a benefit booklet summary; however, under BC Insurance Act s41(5)(b), a group life insured has the statutory right, upon giving reasonable notice, to inspect and obtain a copy of the master policy from the insurer, with the first copy provided free of charge.
Adverse selection control and non-medical basic coverage exchange	adverse selection / non-evidence maximum	The insurer prices coverage based on overall group characteristics and underwrites basic coverage within the non-evidence maximum, on the condition that benefit amounts are strictly predetermined by plan terms; optional additional coverage requires medical underwriting if it exceeds the specified enrolment window (60 days in the exam example) or non-medical limits.
Group life insurance premium and death benefit tax rules	taxable benefit	Group life insurance premiums paid by the employer are included in the employee's taxable income for the year (reported as a taxable benefit on the T4 slip); employee contributions are not tax-deductible and create no taxable benefit; and the life insurance death benefit principal is generally exempt from income tax regardless of who paid the premiums.
Non-Quebec non-medical conversion cap and 31-day window	conversion privilege / CLHIA Guideline G3	In non-Quebec provinces (including BC), a member whose group coverage terminates before or at age 65 can convert to an individual life policy within a 31-day window without evidence of insurability, capped at the lesser of $200,000 or the prior group coverage amount (compared to Quebec's $400,000 limit), provided the application and the first modal premium are fully paid within the window.
Dual benchmarks for conversion window duration and age 65 boundary	conversion privilege	The exam material references 31 days in two sections and 30 days in one section due to editorial discrepancy; candidates should rely on the specific contract figures provided in the question stem; whether coverage terminating on or after the member's 65th birthday qualifies for conversion must be verified against the specific contract and insurer guidelines.
BC provincial insurance premium tax liability	insurance premium tax	The BC insurance premium tax rate on life, accident, and sickness insurance for licensed insurers is 2%, which is reported and remitted by the insurer; this does not constitute an additional 2% personal income taxable benefit for the employee.
Probationary period and actively-at-work thresholds	probationary period / actively-at-work requirement	New employees typically must complete a probationary period (commonly 3 months) and satisfy the contractual actively-at-work requirement on the effective date; coverage may not take effect before the employee is actively performing employment duties.
Four schedule of benefits formats and late-age reduction or termination	membership class / schedule of benefits	Basic coverage is structured as salary multiples, flat amounts, length of service, or combinations thereof and can be tiered by membership class; coverage for retired or senior members typically reduces in stages until terminating completely at a specified age (such as age 70 in the exam examples).
Distinction between dependant life coverage and survivor income benefits	dependant life coverage / survivor income benefits	Dependant life coverage insures spouses and eligible children from 14 days of age up to age 18, 19, or 21 (extended to age 23 to 25 if in full-time study) and frequently uses a flat family premium that does not increase with the number of children; survivor income benefits are monthly income supplements paid on top of the death benefit until the spouse reaches age 65, remarries, or dies.
Group AD&D structures and dependant benefit percentages	basic vs. voluntary AD&D	Basic AD&D is automatically bundled with basic group life coverage, while voluntary AD&D is purchased in units without medical underwriting; under the exam dependant AD&D schedule, covering a spouse alone pays 50% of the member's face amount, whereas covering both a spouse and children reduces the spouse benefit to 40% and provides 15% per child.

Self-test cues (Cornell left column)

1. Why is the point of taxation exactly reversed between group life insurance and group disability insurance when the employer pays the premiums?

2. If a BC group member has a coverage dispute with the insurer, can they look beyond the benefit booklet and obtain a copy of the master policy directly?
3. When a non–Quebec group member exercises the conversion privilege upon termination, what are the maximum coverage limit, the day window, and the mandatory payment action?
4. Why can basic group life coverage be issued without medical evidence, while optional additional coverage requires underwriting once the 60–day window is missed?
5. How do dependant life coverage, monthly survivor income benefits, and dependant AD&D (50% versus 40% / 15%) differ in payout structures and premium rating rules?

Summary: In three sentences, summarize how the group life insurance structure of the employer signing the master contract while members receive coverage dictates adverse selection control, premium–stage taxable benefits, and the non–medical conversion privilege of up to $200,000 within 31 days of termination.

Chapter 7 · Taxation of Life Insurance and Tax Planning Strategies

Life Insurance | P2 Hold steady | Taxation & Strategies · 2 mock questions

Read with these questions: Are policy gains on surrender included in taxable income at 50% or 100%, and how is ACB calculated from premiums and NCPI?; How are policy loans exceeding ACB, collateral assignments for loans, and loan interest deductibility evaluated for tax purposes?; When a corporation receives a $1,000,000 death benefit and the policy ACB is $150,000, how much credits the CDA?; When does an inter vivos transfer to a spouse or child automatically roll over at ACB, and when should a policyholder elect out of the rollover?

How it is tested

- Lifetime disposition and ACB calculation questions: Presenting cumulative premiums, net cost of pure insurance (NCPI), and cash surrender value (CSV) or policy loan amounts, requiring candidates to calculate the adjusted cost basis (ACB), taxable policy gain, or resulting tax payable, testing that policy gains are 100% included in taxable income rather than included at the 50% capital gains rate.
- Disposition action distinction questions: Comparing full surrenders, policy loans, collateral assignments, absolute assignments, or conversions into non-exempt policies, testing which action triggers a disposition or deemed disposition, alongside independent determinations of whether loan principal exceeds ACB and whether loan interest is tax-deductible.
- Intra-family transfer and rollover questions: Describing inter vivos policy transfers between spouses or parents transferring policies to children for no consideration, testing the default application of the spousal rollover, the strategy to elect out of the rollover to utilize business losses, and the statutory requirement that child rollovers must be transferred directly to the child rather than into a trust.
- Corporate-owned life insurance and capital dividend account (CDA) questions: Presenting private corporations receiving death benefits as beneficiaries alongside the policy's ACB, testing that the full death benefit is received tax-free by the corporation, but only the excess of the death benefit over ACB credits the CDA and requires a timely filed Form T2054 election to be distributed tax-free to shareholders.
- Estate planning, charitable giving, and dual-benchmark parameter questions: Combining estate equalization, charitable policy transfers or beneficiary designations, BC probate fees, and the lifetime capital gains exemption (LCGE), testing the receipt differences between inter vivos transfers and testamentary gifts, named beneficiaries bypassing probate, and the distinction between 2022 exam syllabus figures and current tax rules.

Traps (watch for the signal)

Applying the 50% capital gains inclusion rate to policy gains: The question stem mentions a surrender, policy loan, or policy transfer and asks for the taxable income or tax payable.

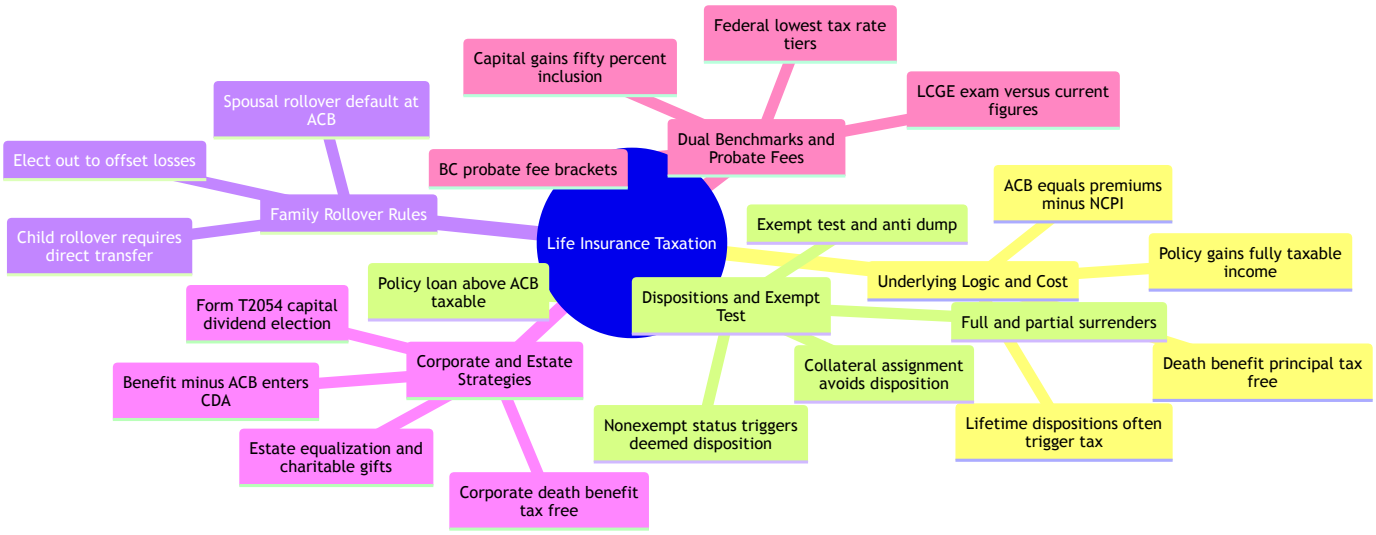
Assuming policy loans are entirely tax-free or confusing interest deductibility: The question stem involves a policyholder taking a policy loan, or mentions loan amount, ACB, and borrowed fund usage (personal spending versus earning taxable investment income).

Confusing collateral assignment with absolute assignment: The question stem mentions assigning the policy as collateral security for a bank loan.

Crediting the full death benefit to the CDA without deducting ACB: The question stem provides a corporate-owned policy's death benefit and a non-zero ACB, asking for the CDA credit or tax-free capital dividend amount.

Reversing spousal or child rollover conditions and default directions: The question stem describes transferring a policy to a spouse during lifetime (especially when the transferor has business losses) or transferring a policy to minor children through a trust.

Mind map


Life Insurance Taxation
Family Rollover Rules
Spousal rollover default at ACB
Elect out to offset losses
Child rollover requires direct transfer
Dual Benchmarks and Probate Fees
Federal lowest tax rate tiers
Capital gains fifty percent inclusion
LCGE exam versus current figures
BC probate fee brackets
Corporate and Estate Strategies
Form T2054 capital dividend election
Benefit minus ACB enters CDA
Estate equalization and charitable gifts
Corporate death benefit tax free
Policy loan above ACB taxable
Dispositions and Exempt Test
Exempt test and anti dump
Nonexempt status triggers deemed disposition
Underlying Logic and Cost
ACB equals premiums minus NCPI
Policy gains fully taxable income
Full and partial surrenders
Collateral assignment avoids disposition
Lifetime dispositions often trigger tax
Death benefit principal tax free

Chapter 7Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Death benefit tax exemption and 100% taxable policy gains	Death benefit & policy gain	The death benefit principal of an exempt life insurance policy is generally not included in the beneficiary's income, but policy gains arising from a lifetime disposition (proceeds of disposition minus ACB) must be 100% included in taxable income for the year and do not qualify for the 50% capital gains inclusion rate.
Adjusted cost basis (ACB) and net cost of pure insurance (NCPI)	Adjusted cost basis (ACB) & NCPI	For G2 and G3 policies, the simplified starting calculation for adjusted cost basis (ACB) is cumulative premiums paid minus cumulative net cost of pure insurance (NCPI), further adjusted for dividends, policy loans, and repayments; because NCPI increases with age, the ACB typically declines in later policy years.
Federal tax brackets, BPA, and LCGE dual benchmarks	LCGE, federal tax brackets & BPA	The general capital gains inclusion rate remains 50%; under the 2022 exam syllabus, the lifetime capital gains exemption (LCGE) limit for qualified small business corporation shares is $913,630, the lowest federal tax bracket is 15%, and the basic personal amount (BPA) is $14,398, whereas under 2026 current rules the LCGE is $1,275,000, the lowest federal rate is 14%, and the maximum BPA is $16,452.
BC probate fee tiering rules	BC probate fee	Under BC probate fee rules, estate values up to $25,000 are exempt, values between $25,000 and $50,000 are charged $6 per $1,000, and values exceeding $50,000 are charged $14 per $1,000 (with the flat court filing fee stated as $208 in the exam syllabus versus $200 currently); naming a beneficiary on a life insurance policy bypasses the estate, exempting the proceeds from probate fees.
Policy loan tax treatment and interest deductibility	Policy loan & interest deductibility	A policy loan constitutes a disposition under tax law; borrowing up to the ACB generates no taxable gain and reduces the ACB dollar-for-dollar, while borrowing in excess of the ACB triggers a taxable policy gain and reduces the ACB to zero; loan repayments can first be deducted against previously reported policy gains before restoring the ACB; loan interest is deductible only when borrowed funds are used to earn taxable income (not solely capital gains or personal expenditures) and verified on Form T2210.
Distinction between collateral assignment and absolute assignment	Collateral assignment vs. absolute assignment	Assigning an exempt life insurance policy to a lender as collateral security does not trigger a disposition of the policy, allowing cash value growth to continue tax-deferred; an absolute assignment transfers policy ownership and constitutes a disposition.
Inter vivos spousal and child policy rollovers	Spousal rollover & child rollover	When both spouses are Canadian tax residents, an inter vivos policy transfer to a spouse automatically rolls over at the ACB by default (though the transferor may elect out of the rollover to realize a gain and offset losses); transferring a policy to a child for no consideration rolls over at the ACB only if transferred directly to the child, and transfers into a trust do not qualify.
Exempt test policy (ETP) and deemed disposition	Exempt test policy (ETP) & deemed disposition	On each policy anniversary, the insurer tests the policy accumulating fund against the exempt test policy (ETP) and anti-dump-in rules; if excess funds are not remedied and the policy becomes non-exempt, a deemed disposition occurs immediately even if no cash is withdrawn, and subsequent annual earnings are taxed on an accrual basis.
Corporate-owned life insurance and the capital dividend account (CDA)	Capital dividend account (CDA)	A private corporation receives a life insurance death benefit completely tax-free, but the amount credited to the capital dividend account (CDA) for tax-free distribution to shareholders is limited to the excess of the death benefit over the policy's ACB; paying a capital dividend to shareholders requires filing Form T2054 on or before the earlier of when the dividend becomes payable or is paid.
Policy tax generations (G1/G2/G3) and dual charitable giving pathways	G1/G2/G3 grandfathering & charitable gift	Policies are categorized into G1, G2, and G3 generations based on issue dates relative to December 2, 1982 and January 1, 2017; converting term to permanent or adding medically underwritten coverage to a G2 policy after 2016 triggers ITA s.148(11) loss of grandfathered status; charitable giving follows two distinct pathways: absolute transfer of ownership (triggering an ITA s.148(7) disposition and donation receipts for fair value and future premiums) versus retaining ownership and naming the charity as beneficiary (no lifetime premium receipts, with the death benefit claimed as a donation credit on final or estate returns).

Self–test cues (Cornell left column)

1. Why is the death benefit tax–free, while policy gains from surrenders or policy loans are 100% included in taxable income?
2. How is the ACB of a G2 or G3 policy calculated, and why does holding a policy longer make an identical policy loan amount more likely to trigger a tax liability?
3. How do policy loans, collateral assignments, and absolute assignments differ regarding disposition status and interest deductibility?
4. How is a corporate–received life insurance death benefit credited to the capital dividend account (CDA) and legally distributed tax–free to shareholders?
5. What are the default rules and statutory exceptions for spousal and child rollovers, and how do 2022 exam syllabus figures differ from 2026 current tax rules?

Summary: In three sentences, summarize the core tax formulas and most frequent exam traps for exempt life insurance policies across three scenarios: death benefits, lifetime dispositions (surrenders, loans, transfers), and corporate CDA distributions.

Chapter 8 · Business Life Insurance: Key Person, Buy–Sell Agreements, and Corporate–Owned Policies

Life Insurance | P2 Hold steady | Business Life Insurance · 1 mock questions

Read with these questions: Why can a commercial loan in good standing become an immediate corporate liquidity crisis upon a key person's death?; When calculating the tax liability on disposing of qualified corporate shares, how are the exam standard and current LCGE benchmarks applied?; When multiple shareholders execute a buy–sell agreement, how can they minimize policy administrative burdens while securing a cost basis step–up?; When a corporation receives a tax–free death benefit, can the entire amount credit the CDA for tax–free distribution to shareholders?

How it is tested

- Scenario distinction questions: Presenting multi–shareholder or partnership business backgrounds (such as changes in participant numbers, or substantial age and health disparities), testing whether to select a cross–purchase, corporate share redemption, or hybrid method, as well as identifying the policyowner, beneficiary, and purchasing party.
- Taxation and cost basis mechanism questions: Comparing the impact of cross–purchase versus corporate share redemption on the surviving shareholders' adjusted cost basis (ACB) and future capital gains, testing whether candidates avoid the trap of assuming that identical shareholding percentages mean equivalent tax consequences.
- CDA and corporate policy fund flow questions: Testing which portion of a tax–free life insurance death benefit received by a corporation can credit the capital dividend account (CDA) for tax–free distribution to shareholders, and how the adjusted cost basis (ACB) of term or permanent life insurance reduces the CDA credit.
- Business risk impact and coverage valuation questions: Combining demand loan recall crises, loss of skills upon a key person's death, or capital gains tax upon deemed disposition, testing the three valuation methods for key person insurance and the statutory conditions for deducting premiums under a collateral assignment.
- Business structure and dual–benchmark rule questions: Comparing sole proprietorships, partnerships, and corporations regarding asset disposition and liability exposure upon the owner's death, alongside eligibility requirements and exam–benchmark calculations for the lifetime capital gains exemption (LCGE).

Traps (watch for the signal)

Assuming identical ownership percentages mean identical mechanisms and tax results: The question stem features two or more shareholders discussing capital gains taxes on a future sale of the business, or asks whether total shares outstanding change and who the purchasing party is.

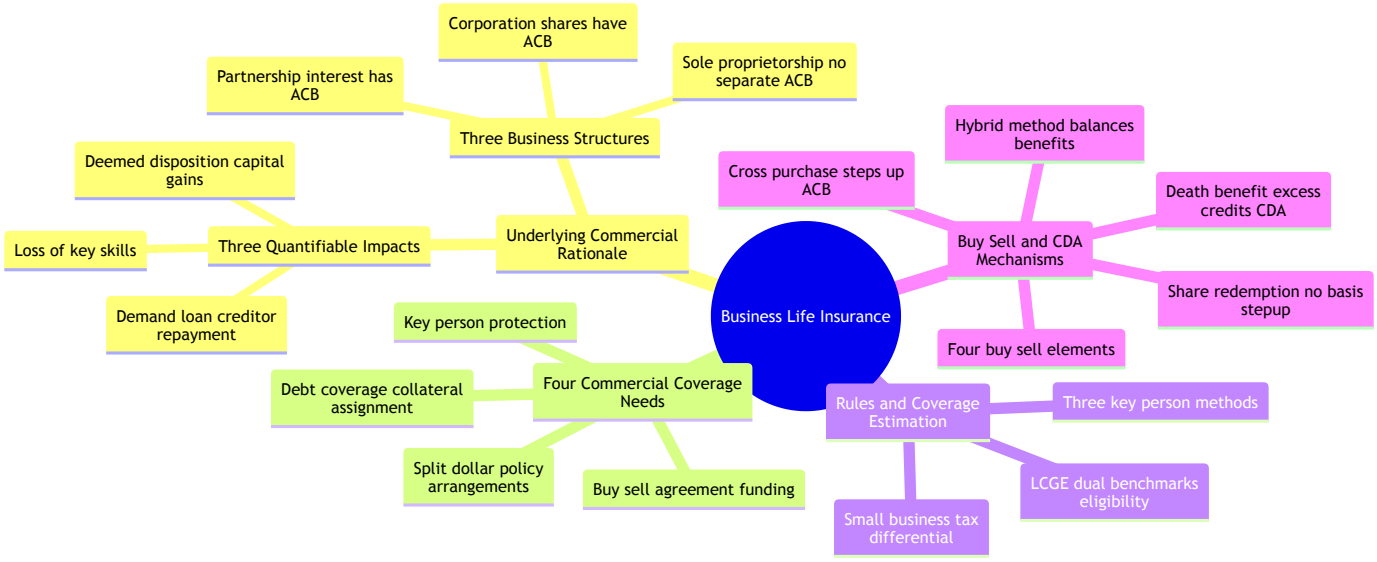
Crediting the full tax–free death benefit to the CDA: The question stem provides the death benefit of a corporate–owned policy alongside a non–zero ACB and asks for the tax–free capital dividend increase.

Assuming equal coverage under criss–cross insurance creates equal premium burdens: The question stem notes significant disparities in age, smoking status, or health conditions between shareholders using criss–cross life insurance.

Believing a demand loan is safe before maturity: The question stem mentions a business relying on a core founder or guarantor with a commercial demand loan on its balance sheet, asking about liquidity risks upon that person's death.

Believing a buy–sell agreement is complete once buyer and valuation are set: The question stem describes shareholders executing a drafted agreement with clear pricing and buyout obligations, but without securing funding vehicles or life insurance policies.

Mind map


Business Life Insurance
Underlying Commercial Rationale
Three Business Structures
Corporation shares have ACB
Partnership interest has ACB
Sole proprietorship no separate ACB
Three Quantifiable Impacts
Deemed disposition capital gains
Loss of key skills
Demand loan creditor repayment
Four Commercial Coverage Needs
Key person protection
Debt coverage collateral assignment
Split dollar policy arrangements
Buy sell agreement funding
Buy Sell and CDA Mechanisms
Cross purchase steps up ACB
Hybrid method balances benefits
Death benefit excess credits CDA
Share redemption no basis stepup
Four buy sell elements
Rules and Coverage Estimation
Three key person methods
LCGE dual benchmarks eligibility
Small business tax differential

Chapter 8Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Three quantifiable financial impacts of business death	loss of skills / creditor demands / capital gains tax	The quantifiable impacts of a key person or owner's death on a business primarily include interim costs from loss of skills, liquidity crises caused by lender demands on demand loans, and capital gains taxes triggered by the deemed disposition of capital property at fair market value immediately prior to death under ITA s.70(5).
Business structures and separate ACB distinctions	sole proprietorship / partnership / corporation	A sole proprietorship is legally identical to its owner and possesses no separate adjusted cost basis (ACB); both partnership interests and corporate shares have a separate ACB that can be bought, sold, or inherited, and a corporation is an independent legal entity whose shareholders are generally not liable for corporate debts (absent personal guarantees or statutory director liabilities).
Insurable interest principle in business contexts	insurable interest	The core test of insurable interest is whether the policyowner will suffer a genuine financial loss upon the death of the life insured (including a business insuring key employees, creditors insuring debtors, and partners or shareholders insuring each other); coverage must reasonably correspond to the anticipated financial loss and satisfy financial underwriting.
Lifetime capital gains exemption (LCGE) dual benchmarks and eligibility	lifetime capital gains exemption (LCGE)	Under the 2022 exam standard, the lifetime capital gains exemption (LCGE) limit for qualified small business corporation (QSBC) shares is $913,630 ($1,000,000 for qualified farm and fishing property), whereas the 2026 current limit is $1,275,000 (providing a cumulative deduction of $637,500 at the 50% inclusion rate); ordinary commercial partnership interests are ineligible, but qualifying family farm or fishing partnerships may qualify.
Three key person insurance valuation methods	key person insurance valuation	The industry commonly cross-references the income/salary multiple method, the profit contribution method (gross profit contribution share multiplied by replacement years), and the replacement and debt protection method (headhunter fees, training dual-salary costs, and outstanding balances of tied demand loans), rather than taking a simple mathematical average.
Four essential conditions of an enforceable buy-sell agreement	guaranteed buyer / guaranteed value / mandatory sale / guaranteed funding	A fully workable buy-sell agreement must simultaneously satisfy four conditions: guaranteed buyer, guaranteed value, mandatory sale, and guaranteed funding; guaranteed funding (typically provided by life insurance) is the most critical element to prevent the agreement from becoming unenforceable.
Core distinctions between cross-purchase and share redemption	cross-purchase agreement vs. share redemption (entity purchase)	Under a cross-purchase agreement, shareholders insure each other and purchase shares directly, keeping total shares constant and giving the survivor a cost basis step-up on purchased shares, but multiple owners cause policy counts to multiply and health/age disparities create unequal premium burdens; under share redemption, the corporation owns policies and cancels redeemed shares, reducing total share count and requiring only one policy per shareholder, but providing no cost basis step-up to survivors.
Dual advantages of the hybrid method using promissory notes	hybrid method (promissory note)	Under the hybrid method, the corporation owns the policies and receives the tax-free death benefit to credit its CDA, then distributes a tax-free capital dividend to surviving shareholders, who use those funds to repay the promissory notes issued to the estate for purchasing the deceased shareholder's shares; this achieves both a streamlined policy count and a cost basis step-up for the survivors.
Capital dividend account (CDA) credit rules and reporting	capital dividend account (CDA) / Form T2054	When a private corporation receives a tax-free life insurance death benefit, only the excess over the policy's adjusted cost basis (ACB) credits the capital dividend account (CDA), which can then be distributed tax-free to Canadian-resident shareholders by filing Form T2054 under ITA s.83(2).
Collateral assignment of policies and loan premium deductibility	collateral assignment	Pledging a policy to a restricted financial institution as loan collateral constitutes a collateral assignment rather than an absolute transfer and does not trigger a disposition; where loan interest is deductible and ITA s.20(1)(e.2) requirements are met, a tax deduction is allowed for the portion of the lesser of annual premium and net cost of pure insurance (NCPI) that reasonably corresponds to the outstanding loan balance.

Self-test cues (Cornell left column)

1. Why do sole proprietorships, partnerships, and corporations experience different depths of tax and liability impact upon an owner's death?
2. What four conditions must a buy–sell agreement satisfy, and why is guaranteed funding the most critical element?
3. How do cross–purchase, share redemption, and hybrid methods differ regarding policy count, total shares outstanding, and the survivor's adjusted cost basis (ACB)?
4. Which portion of a tax–free life insurance death benefit received by a corporation can credit the capital dividend account (CDA) for tax–free distribution to shareholders?
5. Why does criss–cross insurance expose severe structural flaws when shareholders exceed two or have substantial age and health disparities?

Summary: In three sentences, summarize the core tax and structural logic of purchasing key person life insurance, structuring buy–sell agreement funding (cross–purchase vs. share redemption vs. hybrid method), and distributing proceeds through the CDA.

Chapter 9 · Application and Underwriting

Life Insurance P1 Must score Application & Underwriting · 3 mock questions

Read with these questions: Between smoking cigarettes and weekend extreme skydiving, which one actually causes a policy to become a rated policy?; If a client pays the first month's premium but checks 'yes' to an illness on the TIA questionnaire, can temporary coverage take effect?; Can an underwriter issue a decline notice solely upon finding a hazardous hobby code in the MIB database?; If the client is diagnosed with a critical illness after policy issue but before delivery, can the agent deliver the policy?; Does a life insurance policy purchased on a spouse automatically become void after the couple divorces?

How it is tested

- Lifestyle and premium impact discrimination questions: The question stem provides an applicant's background such as smoking status, occasional alcohol use, or high-risk extreme sports, testing which factors merely determine standard rate classification (such as smoker versus non-smoker standard rates) and which factors actually trigger a rating or an exclusion clause.
- Underwriting information sources and authority boundaries questions: Centering on agent field underwriting, Medical Information Bureau (MIB) coded records, Attending Physician's Statements (APS), and Motor Vehicle Records (MVR), testing who pays the costs, whether an agent can assign risk classifications on behalf of underwriters, and whether an MIB record alone can serve as direct grounds for decline.
- Temporary Insurance Agreement (TIA) and policy delivery validity questions: Setting scenarios of health changes or answering 'yes' on questionnaires during the gap between application submission and policy delivery, testing automatic TIA disqualification conditions, agent issuance discretion, and the precondition that insurability must remain unchanged upon policy delivery.
- Misrepresentation and two-year incontestability questions: Comparing innocent mistakes, deliberate fraudulent misrepresentations, and misstatements of age on the application, testing the legal boundaries of protection once the contract has been in force for two years during the lifetime of the insured, and why fraud is never protected by incontestability.
- Dual benchmarks and underwriting channel comparison questions: Testing the core difference between accelerated underwriting and simplified issue regarding whether risk classification tiers are retained, as well as the compliance boundary between asking about family medical history (permitted) and demanding genetic test results (prohibited by the Genetic Non-Discrimination Act).

Traps (watch for the signal)

Confusing standard rate classification with premium ratings: The question stem lists smoking, occasional social drinking, and frequent high-risk sports, asking which item will cause the policy to be rated or issued with an exclusion clause.

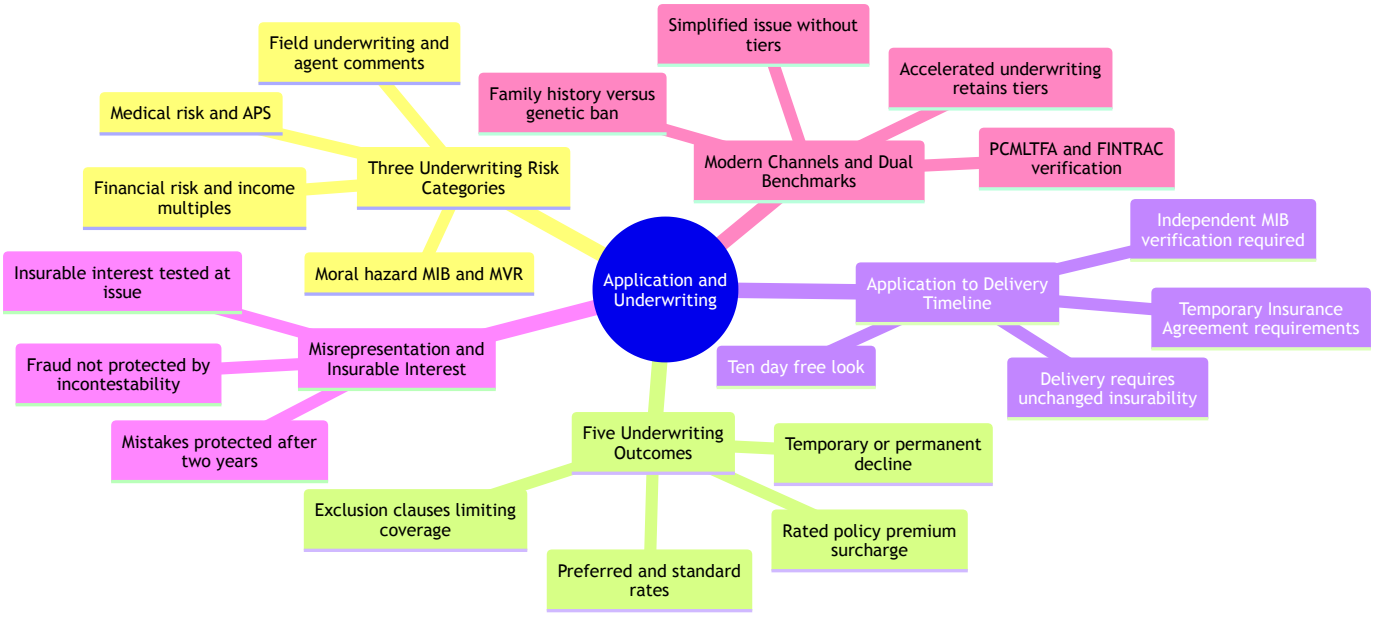
Assuming an MIB report can serve directly as grounds for decline: Options contain absolute statements such as declining or rating solely based on the MIB report.

Believing paying the first premium guarantees TIA coverage: The question stem mentions an applicant paying the first month's premium but answering 'yes' to an item on the TIA health questions, or the agent observing abnormalities like persistent severe coughing.

Treating insurable interest as an ongoing requirement at claim time: The question stem features a scenario where a couple or business partners bought insurance years ago and are now divorced or separated, asking whether the existing policy remains valid or if a new policy can be added.

Confusing innocent mistakes with fraud under the two-year incontestability rule: The question stem clearly distinguishes whether the applicant made an innocent mistake or committed deliberate fraud concealing medical or smoking history, providing a timeline where the policy has been in force for two years during the insured's lifetime.

Mind map


Application and Underwriting
Three Underwriting Risk Categories
Field underwriting and agent comments
Medical risk and APS
Financial risk and income multiples
Moral hazard MIB and MVR
Modern Channels and Dual Benchmarks
Simplified issue without tiers
Family history versus genetic ban
Accelerated underwriting retains tiers
PCMLTFA and FINTRAC verification
Misrepresentation and Insurable Interest
Insurable interest tested at issue
Fraud not protected by incontestability
Mistakes protected after two years
Application to Delivery Timeline
Independent MIB verification required
Temporary Insurance Agreement requirements
Delivery requires unchanged insurability
Ten day free look
Five Underwriting Outcomes
Temporary or permanent decline
Rated policy premium surcharge
Preferred and standard rates
Exclusion clauses limiting coverage

Chapter 9Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Field underwriting and agent authority boundaries	Field underwriting / Agent's comments	Acting as the insurer's eyes, the agent is responsible for collecting information, verifying identity, witnessing signatures, and recording personal observations in the agent's comments section, but cannot replace the underwriter in deciding risk classifications or alter health answers on behalf of the applicant.
Three underwriting risk categories and information sources	Physical/medical risk, Financial risk, Moral hazard	Underwriting comprehensively evaluates medical risk (questionnaires, medical exams, APS, MIB), financial risk (occupation, income, net worth, existing coverage), and moral hazard (MIB, MVR, inspection reports, agent's comments).
Difference between standard rate classification and premium ratings	Standard rate classification vs. Rated policy	Smoking status determines whether the applicant qualifies for the smoker or non-smoker standard rate table, whereas frequent high-risk sports, hazardous travel, or severe driving violations trigger a premium rating (rated policy) or an exclusion clause on top of standard rates.
Unilateral contract protection and removal of rating	Unilateral protection / Removal of rating	Once in force with guaranteed renewability, a life insurance policy will not be re-rated with a premium surcharge simply because the insured's health deteriorates, but if the cause of a rating ceases to exist (such as quitting smoking for the required period), the policyowner can apply for a reduction or removal of the rating.
Mechanisms distinguishing accelerated underwriting from simplified issue	Accelerated underwriting vs. Simplified issue	While both eliminate traditional medical exams, accelerated underwriting uses algorithms and existing data for comprehensive evaluation and retains risk classifications such as preferred, standard, and rated, whereas simplified issue uses short questionnaires and instant data to accept or decline without tiering, typically charging higher premiums.
Dual benchmarks of family history and genetic testing	Family history vs. Genetic Non-Discrimination Act (GNDA)	Asking about family medical history of parents and siblings on an application is entirely legal, but the Genetic Non-Discrimination Act (GNDA) strictly prohibits requiring genetic testing or disclosing genetic test results as a condition of insurance.
Temporary Insurance Agreement (TIA) validity and disqualification rules	Temporary Insurance Agreement (TIA) / Conditional receipt	Applying for a TIA requires submitting a complete formal application, paying at least one month of premium, and completing a separate TIA questionnaire; if any question on the TIA health questionnaire is answered 'yes' or if the agent observes health concerns, a TIA must not be issued.
Underwriting rules for MIB and APS	Medical Information Bureau (MIB) / Attending Physician's Statement (APS)	An Attending Physician's Statement (APS) is requested by the insurer from the applicant's physician at the insurer's expense; the Medical Information Bureau (MIB) shares coded risk clues, but an insurer must never decline an application solely based on an MIB report and must independently verify the facts first.
Policy delivery validity requirements and ten-day free-look period	Policy delivery / Insurability unchanged / 10-day free-look	Policy delivery is a continuation of the underwriting process, requiring confirmation that the initial premium is paid in full, the policyowner accepts the policy, and the insured's insurability has not changed since the application; receipt of the policy begins a free-look period of at least 10 days for unconditional cancellation and premium refund.
Innocent mistake, fraud, and timing of insurable interest	Mistake vs. Fraudulent misrepresentation / Insurable interest	Innocent material mistakes are protected by incontestability once the contract has been in force for two years during the lifetime of the insured without fraud, whereas fraudulent misrepresentation is never protected; insurable interest is required only at policy issue, and a subsequent divorce does not affect the validity of the existing contract.

Self-test cues (Cornell left column)

1. Why does a smoker paying a higher premium not count as a rated policy, and what factors actually trigger a rating or an exclusion clause?

2. What authorities and restrictions does an agent have during field underwriting and when issuing a Temporary Insurance Agreement (TIA)?
3. Why can an underwriter not decline coverage solely upon discovering an adverse MIB code, and what step must be taken first?
4. If the insured experiences a material health change between policy issuance and formal delivery, what must the agent do?
5. What is the fundamental difference between innocent mistakes and fraudulent misrepresentation under the two-year incontestability rule, and how are family medical history and genetic test results distinguished under compliance rules?

Summary: Summarize the core of this chapter in three sentences: First, distinguish the three risk categories and five underwriting outcomes (especially the difference between smoker rate classification and ratings); second, connect the strict procedural constraints from TIA and independent MIB verification to confirming unchanged insurability at delivery; third, articulate the two-year incontestability rule and the compliance boundaries under GNDA and FINTRAC.

Chapter 10 · Assessing the Client's Situation: Determining Life Insurance Needs (Income Replacement vs. Capital Needs Approach)

Life Insurance | P1 Must score | Assessing Needs · 6 mock questions

Read with these questions: When the question stem gives both property market value and mortgage balance, and mentions group life insurance, how do you calculate recommended new coverage?; When the income replacement approach accounts for both marginal tax rates and inflation, how is capitalized value calculated step by step?; If a divorce mediation agreement does not explicitly require buying life insurance, does the child support obligation automatically disappear upon death?; When a client holds ongoing qualified small business corporation shares and partnership interests, how are death taxes and available assets calculated?

How it is tested

- Scenario net coverage calculation questions: The question stem provides household monthly expenses, government survivor benefits, property market value and mortgage balance, and existing group insurance, testing your ability to calculate the recommended new insurance amount using the capital needs approach, focusing on whether you mistakenly use property market value instead of mortgage balance and whether you omit deducting existing coverage.
- Income replacement approach four-step adjustment questions: The question stem provides annual after-tax income, investment rate of return, marginal tax rate, and inflation rate, testing your ability to distinguish the capitalized value formulas and result differences across four steps: unadjusted, after-tax adjustment only, inflation adjustment only, and dual adjustment for both taxes and inflation.
- Capital retention versus capital drawdown discrimination questions: The question stem provides dependency needs with a definite end date or permanent spousal income needs, testing your ability to determine when to use the capital drawdown method versus the capital retention method, and how choosing the wrong method distorts the required coverage amount.
- Complex family and business situation assessment questions: Involving mediation agreement support payments in blended families, return-to-work plans for caregiving spouses, and deemed disposition of sole proprietorships, partnerships, and qualified small business corporation (QSBC) shares, testing which hidden liabilities from the six-element checklist must be included and which non-liquid assets must be excluded.
- Exam benchmark versus current rule dual-benchmark questions: Centering on Canada Pension Plan (CPP) survivor benefits, the lifetime capital gains exemption (LCGE), and group life conversion windows, testing your ability to answer on the exam according to the question

Traps (watch for the signal)

Using property market value instead of mortgage balance: The question stem lists both property market value and mortgage balance figures.

Omitting deduction of available existing coverage: The end of the question stem mentions employer-provided group life insurance, existing personal policies, or corporate policies tied to buy-sell agreements.

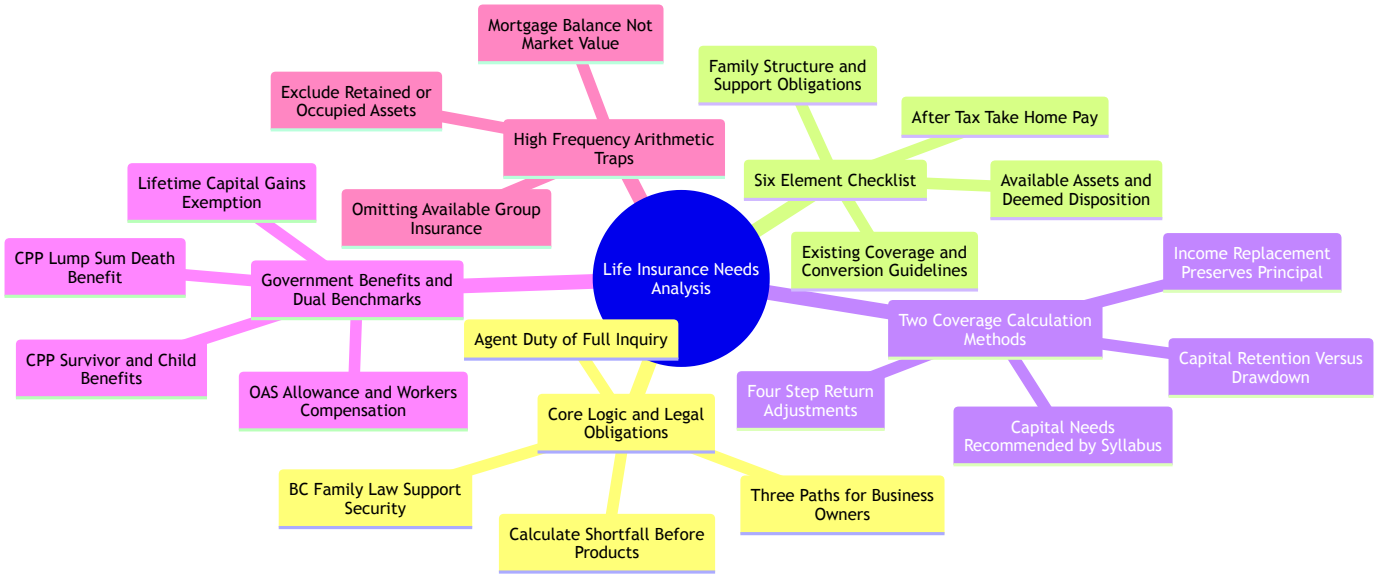
Mixing illiquid non-saleable assets into the available asset pool: The question stem includes wording restricting liquidation such as the spouse will continue living in, the family plans to retain and continue operating, or passing down to children.

Confusing the capital retention method with the capital drawdown method: The question stem specifies a definite number of years to cover (such as 10 or 14 years), a milestone child age, or provides rate of return, tax rate, and inflation rate percentages simultaneously.

Confusing exam legacy benchmarks with current rules: The question stem involves the CPP lump-sum death benefit, monthly survivor and child benefits, or LCGE amounts, or mentions general operating partnerships versus qualified small business corporation (QSBC) shares.

stem and exam benchmarks while identifying traps of overly optimistic assumptions using maximum amounts.

Mind map



Chapter 10Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Needs analysis independent of product recommendations	needs analysis approach	The needs analysis approach is an independent financial analysis document that precedes product recommendations, designed to calculate the family's coverage shortfall if that income were lost, rather than immediately determining which policy to buy.
Spousal support and court-ordered insurance obligations	court-ordered insurance	Under British Columbia's Family Law Act s. 170(e) and s. 171, even if a mediation agreement does not explicitly require purchasing insurance, as long as the support obligation does not state that it terminates upon death, the former spouse may still claim against the estate.
Lifetime capital gains exemption dual benchmarks and eligibility	lifetime capital gains exemption (LCGE)	Under the 2022 exam benchmark, the limit for qualified small business corporation (QSBC) shares is $913,630 ($1,000,000 for farming and fishing), whereas the 2026 current indexed limit is $1,275,000; general operating partnerships are ineligible, but qualified family farm or fishing partnership interests may qualify.
CPP survivor and death benefit dual benchmarks	CPP survivor benefits	The basic CPP lump-sum death benefit is $2,500 (starting in 2025, an additional $2,500 top-up to $5,000 is available under specific conditions such as having no eligible survivor and no prior retirement or disability benefits); for monthly benefits, the exam uses values from the question stem or 2022 snapshot ($674.79 for under 65, $752.15 for 65 and older, and $264.53 for children), whereas the 2026 current maximums are $803.54, $904.59, and $307.81 for children.
Income replacement approach and four-step return adjustments	income replacement approach	Divide after-tax take-home pay by the investment rate of return to determine the capitalized value; the after-tax rate of return is calculated as return x (1 – tax rate), and the inflation-adjusted rate of return is calculated as (1 + return) / (1 + inflation rate) – 1.
Capital needs approach core formula	capital needs approach	The exam framework recommends the capital needs approach: first calculate the survivor income shortfall (post-death expenses minus post-death income) and capitalize it, add one-time capital needs to arrive at total capital needs, and then subtract assets available upon death and existing coverage to determine the capital shortfall.
Choosing between capital retention and capital drawdown methods	capital retention method / capital drawdown method	Long-term income replacement without a definite end date uses the capital retention method (preserving principal permanently and spending only interest); needs with a definite duration use the capital drawdown method (exhausting principal over time, which equals annual shortfall x number of years under a zero net real return assumption).
Mortgage balance and defining available assets	assets available upon death	Net mortgage needs include only the remaining mortgage balance, not property market value; the family home where a surviving spouse will continue living or corporate shares the family plans to retain and operate are excluded from the liquid pool of assets available upon death.
Existing group life deductions and conversion privilege boundaries	existing coverage review	Existing coverage can be deducted from total capital needs only after confirming it is payable upon death, available for family needs, and not earmarked for other purposes such as buy-sell agreements; in BC, group life conversion privileges upon employment termination rest solely on CLHIA industry guidelines (with the exam text citing both 30-day and 31-day windows).

Self-test cues (Cornell left column)

1. Why must needs analysis be independent of product recommendations, and what does BC family law provide regarding spousal support and life insurance?
2. What are the amounts for CPP death benefits, monthly survivor and child benefits, and the LCGE under the 2022 exam snapshot versus 2026 current standards?
3. How are the four-step rate of return adjustments calculated under the income replacement approach, and why does the syllabus recommend the capital needs approach?
4. What scenarios do the capital retention and capital drawdown methods apply to, and should mortgage needs use market value or mortgage balance?

5. When calculating recommended new coverage, which assets must be excluded from the available asset pool, and which existing coverage cannot be directly deducted?

Summary: Summarize the core of this chapter in three sentences: First, explain the underlying assumption differences between the income replacement and capital needs approaches; second, trace the complete deduction chain from total capital needs to recommended new coverage; third, articulate the key rules to avoid traps regarding mortgages, illiquid assets, and dual-benchmark statutory figures.

Chapter 11 · Recommending an Insurance Policy

Life Insurance | P1 Must score | Recommending · 4 mock questions

Read with these questions: Why is it wrong to default to recommending the largest and most comprehensive whole life policy when a client's cash flow is tight?; How should candidates answer exam questions regarding the statutory basis of the LIRD replacement disclosure form and the Quebec exception?; Why must illustrations containing non-guaranteed values display two scenarios, and what does the client's signature signify?; When an expiring term policyholder has started smoking, why might renewing the existing policy be more advantageous than buying a new one?; What is the distinction between intra-company and cross-company replacements regarding improper conduct, and when can the old policy be cancelled?

How it is tested

- Product type and duration matching questions: Presenting a client's specific risks (such as a mortgage, income replacement, death tax liability, or lifelong support for a special needs child) and cash flow situation, testing the selection of term insurance, convertible term insurance, or permanent insurance using duration of risk as the primary criterion.
- Multi-option cost comparison and renewal decision questions: Testing cumulative cost analysis rather than merely looking at first-year premiums, or comparing the pros and cons of renewing at the original health rating versus undergoing new underwriting to purchase a new policy when an expiring term policyholder's health has deteriorated (such as starting to smoke).
- Policy illustration compliance and signature significance questions: Testing the distinctions between term insurance illustrations and permanent insurance illustrations containing non-guaranteed amounts, the separate presentation of guaranteed versus non-guaranteed values, the requirement for at least two scenarios, and that the client's signature signifies only understanding the nature of the illustration rather than an insurer guarantee of projected returns.
- Policy replacement disclosure and procedural sequence questions: Testing the intra-company versus inter-company distinction between churning and twisting, the scope of application of the Life Insurance Replacement Declaration (LIRD) (with Quebec using its own specific form), the requirement that disclosure is still mandatory even when initiated by the client, and the rule that the existing policy must only be cancelled after the new policy is in force and accepted by the client.
- Client refusal or partial acceptance record-keeping questions: Testing how an agent uses a written reason-why record to document uncovered gaps and obtain client acknowledgement when the client purchases only partial coverage due to budget constraints or refuses the recommendation entirely, rather than applying pressure or abandoning documentation.

Traps (watch for the signal)

Misplaced objective (treating the most expensive and comprehensive option as the default best): The question stem emphasizes that the client currently has limited income or tight cash flow, while options feature an expensive full whole life combination.

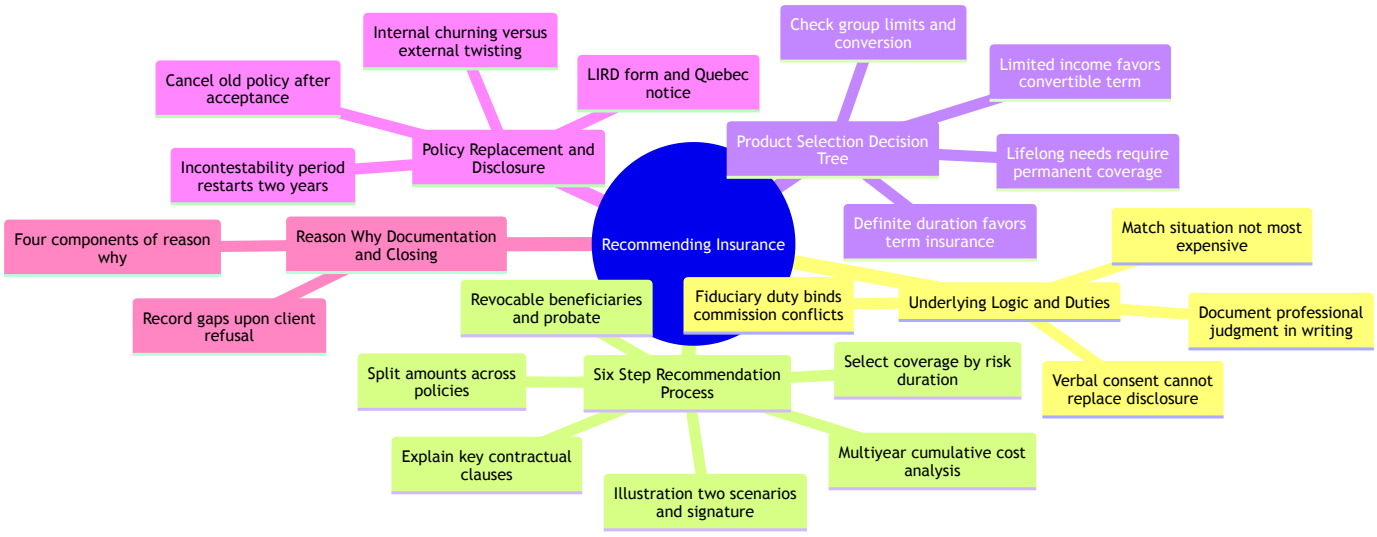
Missing a step (looking only at first-year premiums or overlooking original health rating lock-in): The question stem presents a comparison of term insurance combinations with different durations, or an expiring policyholder whose health has worsened or who started smoking having to decide between renewal and new coverage.

Jurisdictional confusion (revocable beneficiary default versus Quebec replacement form): The question stem mentions naming a spouse as beneficiary without specifying whether it is revocable, or asks about differences between Quebec and other provinces regarding policy replacement disclosure forms.

Similar terms with different rules (confusing churning with twisting): The question stem describes an agent inducing a client to surrender an old policy for a new one, explicitly noting whether it occurs within the same insurer or across different insurers.

Misapplied premise and inverted process (assuming client-initiated replacements waive disclosure or cancelling the old policy prematurely): The question stem states that the client actively requested replacing an existing policy, or asks when the existing policy should be cancelled during underwriting of the new policy.

Mind map


Recommending Insurance
Policy Replacement and Disclosure
Internal churning versus external twisting
LIRD form and Quebec notice
Cancel old policy after acceptance
Incontestability period restarts two years
Reason Why Documentation and Closing
Four components of reason why
Record gaps upon client refusal
Product Selection Decision Tree
Check group limits and conversion
Limited income favors convertible term
Lifelong needs require permanent coverage
Definite duration favors term insurance
Underlying Logic and Duties
Match situation not most expensive
Document professional judgment in writing
Verbal consent cannot replace disclosure
Fiduciary duty binds commission conflicts
Six Step Recommendation Process
Revocable beneficiaries and probate
Split amounts across policies
Explain key contractual clauses
Illustration two scenarios and signature
Multiyear cumulative cost analysis
Select coverage by risk duration

Chapter 11Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Duration of risk determines policy type	duration of risk	Needs with a definite termination horizon favor term insurance, lifelong needs favor permanent insurance, and uncertain needs with limited income favor convertible term insurance to preserve future options.
Multi-year cumulative cost analysis	cumulative cost analysis	When comparing renewing a single term policy against combinations of term policies with different durations, one must compare multi-year cumulative total premiums rather than just looking at first-year premiums, because the magnitude of renewal premium jumps determines long-term cost.
Default revocable beneficiary rule	revocable vs irrevocable beneficiary	Except in Quebec where designating a married or civil union spouse in writing outside a will is irrevocable by default, beneficiary designations across all other Canadian provinces are revocable by default, and establishing an irrevocable designation requires an explicit declaration.
Policy illustration scenarios and signature significance	policy illustration	Life insurance illustrations containing non-guaranteed values must clearly distinguish between guaranteed and non-guaranteed values and display at least two scenarios; the client's signature confirms understanding the nature of the illustration rather than an insurer guarantee that the projected returns will be achieved.
Definition of churning versus twisting	churning vs twisting	Using misleading or false information to persuade a client to replace a policy or withdraw cash to buy a new policy within the same insurer is called churning; when occurring between different insurers, it is called twisting; both violate fiduciary duty.
Life Insurance Replacement Declaration and jurisdictional statutory basis	life insurance replacement declaration (LIRD)	The exam standard broadly states that most jurisdictions require the use of the LIRD (while Quebec uses its own specific Notice of Replacement of Insurance Contract), whereas practicing in BC requires knowing that section 3(4) of the Insurance Contract (Life Insurance Replacement) Regulation provides the explicit statutory basis.
Replacement pros and cons and new incontestability period	incontestability period	Replacing a policy causes a new two-year incontestability period to restart on the new policy, forfeits the cash value of the old policy that has already amortized early acquisition costs, and subjects the client to new underwriting and pricing based on current age and health status.
Statutory sequence for cancelling old policy in a replacement	policy replacement	Replacement disclosure must be fulfilled regardless of who initiated the replacement, and the existing policy must only be cancelled after confirming the new policy is formally in force and accepted by the client to prevent a coverage gap.
Written reason-why record and handling client refusal	reason-why record	Every substantive recommendation should record a summary of the client's situation, alternatives considered and trade-offs, the final recommendation matched to specific needs, and the client's response; if the client purchases only partial coverage or declines, the uncovered risk gap must be documented in writing.

Self-test cues (Cornell left column)

1. Why can verbal consent never replace written disclosure and signed documentation during the recommendation phase?
2. What are the six steps of the recommendation process from calculating coverage to client signature and acceptance?
3. What standards must permanent life policy illustrations containing non-guaranteed values meet, and what does the client's signature signify?
4. What is the difference between churning and twisting, and why must the old policy never be cancelled before the new one is accepted?
5. How should an agent handle situations where a client faces term renewal after health has deteriorated or declines full recommended coverage due to budget, and how should the reason-why record be written?

Summary: In three sentences, summarize how to match products based on duration of risk and cash flow, how to fulfill written disclosure during illustration and replacement to prevent conflicts of interest, and how to complete documentation

when a client compromises or refuses.

Chapter 12 · Ongoing Policy Service

Life Insurance | P2 Hold steady | Ongoing Service · 3 mock questions

Read with these questions: When a smoker quits smoking and applies for non–smoker rates, or when a policyowner assigns a policy to a bank as collateral, which request requires medical underwriting?; When applying to reinstate a policy 55 days after it lapsed at the end of the grace period, is simply paying overdue premiums sufficient?; If a client divorces, remarries, and verbally asks their agent to change the beneficiary to the current spouse, who receives the death benefit upon the client's death?; If claim verification reveals that the applicant's age was understated by 3 years without fraud, will the insurer deny the claim or adjust the death benefit proportionally?; How long must a life insured be missing before applying for a declaration of presumption of death, and does the standard exam answer align with BC provincial legislation?

How it is tested

- Policy change classification questions: Given client change requests (such as increasing the face amount, changing smoker status, changing beneficiaries, or policy assignments), tests whether each change triggers medical underwriting or tax disposition rules.
- Premium default and reinstatement timeline questions: Given the number of overdue days and the living or health status of the life insured, tests the boundaries between the 30–day grace period, the 30–day post–grace period reinstatement window without medical underwriting, and the 2–year conditional reinstatement window.
- Beneficiary designation and protection questions: In scenarios involving marital changes, oral notifications, irrevocable beneficiaries, or creditor recovery, tests the written declaration formal requirements, lifetime filing rules, and the scope of creditor protection.
- Policy replacement and compliance process questions: Centered on internal churning versus external twisting, tests the timing for signing the Life Insurance Replacement Declaration (LIRD), mandatory disclosure of advantages and disadvantages, and the principle of keeping the existing policy in force until the new policy takes effect.
- Claim adjudication and statutory presumption questions: Centered on proportional death benefit adjustments for misstatement of age, the simultaneous death presumption, payment into court, and the dual–benchmark difference between the 7–year exam standard and BC statutory provisions for presumption of death.

Traps (watch for the signal)

The dual 30–day continuous coverage trap: The question stem describes the life insured dying N days after the grace period expires, and family members attempt to pay overdue premiums and demand a claim payment.

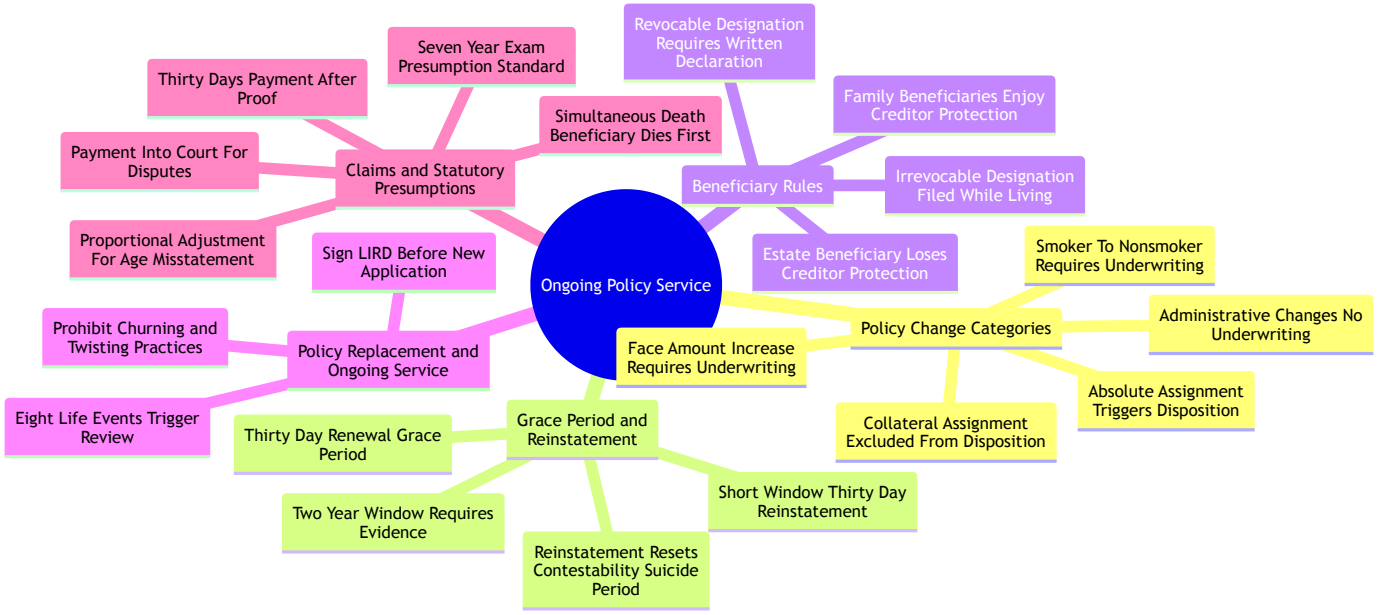
The oral or automatic beneficiary change trap: The question stem features a divorce or remarriage without updating policy documents, verbal instructions given to an agent to change the beneficiary, or the life insured dying before written documents are delivered.

The age misstatement claim denial or inverted ratio trap: The question stem reveals an unintentional age error during claim settlement, providing the original face amount, actual premium paid, and correct premium payable for the true age.

The 2–year unconditional reinstatement trap: The question stem presents a policy that has been lapsed for more than 30 days but less than 2 years (such as 55 days post–lapse), where the client requests immediate policy reinstatement simply by paying overdue premiums.

The exam standard versus BC statutory rule confusion trap: The question stem involves applying for a declaration of presumption of death after years of disappearance, or an attorney under an enduring power of attorney (POA) attempting to alter an existing policy beneficiary designation.

Mind map


Ongoing Policy Service
Claims and Statutory Presumptions
Seven Year Exam Presumption Standard
Thirty Days Payment After Proof
Simultaneous Death Beneficiary Dies First
Payment Into Court For Disputes
Proportional Adjustment For Age Misstatement
Beneficiary Rules
Revocable Designation Requires Written Declaration
Family Beneficiaries Enjoy Creditor Protection
Irrevocable Designation Filed While Living
Estate Beneficiary Loses Creditor Protection
Policy Change Categories
Smoker To Nonsmoker Requires Underwriting
Administrative Changes No Underwriting
Face Amount Increase Requires Underwriting
Absolute Assignment Triggers Disposition
Collateral Assignment Excluded From Disposition
Grace Period and Reinstatement
Thirty Day Renewal Grace Period
Short Window Thirty Day Reinstatement
Two Year Window Requires Evidence
Reinstatement Resets Contestability Suicide Period
Policy Replacement and Ongoing Service
Sign LIRD Before New Application
Prohibit Churning and Twisting Practices
Eight Life Events Trigger Review

Chapter 12Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Distinction between administrative and underwriting changes	administrative change vs. underwriting change	Changes to name, address, premium payment frequency, deleting riders, and changing revocable beneficiaries are administrative changes requiring no medical underwriting; increasing coverage amounts, adding riders, and changing from smoker to non-smoker status generally require evidence of good health or insurability, unless exercised under a guaranteed insurability option or contractual conversion privilege.
Tax classification of policy ownership assignments	assignment (absolute / collateral)	Neither absolute assignments nor collateral assignments require medical underwriting; however, an absolute assignment permanently transfers ownership and generally constitutes a disposition of interest subject to taxation, whereas a pure collateral assignment is expressly excluded from the definition of disposition under Income Tax Act section 148.
Renewal premium grace period	grace period	When an overdue renewal premium is unpaid, the policy enters a grace period of 30 days (28 days for industrial life insurance) starting the day after the due date, or the longer period specified in the contract; if an insured event occurs during this period, the contract remains valid, and the insurer may deduct the overdue premium (in individual and creditors' group insurance).
Two-tier reinstatement windows for lapsed policies	reinstatement	After a policy lapses at the end of the grace period due to unpaid premiums, it can be reinstated within an additional 30-day window without evidence of good health provided the life insured is still alive when payment is made; if requested after 30 days but within 2 years of lapse, the policyowner must pay all overdue premiums, policy indebtedness, and statutory capped interest, and present evidence of insurability and good health satisfactory to the insurer, upon which the insurer is legally required to reinstate the contract.
Beneficiary designation formalities and irrevocable filing	revocable / irrevocable beneficiary & declaration	A revocable beneficiary change must be effected within the contract or by a signed written declaration, as oral instructions are legally void; an irrevocable beneficiary designation cannot be made in a will and must be filed at the insurer's head or principal office in Canada during the lifetime of the life insured, and any subsequent dealing with the contract requires verifying that the irrevocable beneficiary is at least 19 years old and obtaining their consent.
Creditor protection and estate beneficiary risks	creditor protection & estate beneficiary	Once insurance proceeds fall due, money designated to a beneficiary does not form part of the estate and is exempt from creditor claims; during the contract's lifetime, designating the spouse, child, grandchild, or parent of the life insured exempts the contract rights from execution or seizure, whereas designating the estate forfeits this statutory creditor protection.
Policy replacement compliance and prohibited replacements	life insurance replacement declaration (LIRD), churning & twisting	When a replacement is involved, the agent must provide and explain the Life Insurance Replacement Declaration (LIRD) alongside a written statement of advantages and disadvantages before submitting the application, obtaining signed acknowledgments from the applicant and insured; the existing policy must be maintained until the new policy takes effect, and misleading internal churning or external twisting is strictly prohibited.
Age misstatement benefit adjustments and reinstatement reset	misstatement of age, incontestability period & suicide clause	An unintentional misstatement of age is not protected by the 2-year incontestability period and adjusts the death benefit proportionally using the formula 'Original Face Amount x Premium Paid / Premium Payable' (if the true age exceeds insurable limits while the insured lives, the insurer may rescind within 5 years of issue and within 60 days of discovery); reinstatement resets the disclosure rules and the suicide exclusion clause (typically 2 years) from the most recent reinstatement date.
Claims payment deadline, simultaneous death, and payment into court	proof of claim, simultaneous death presumption & payment into court	The insurer must pay the insurance money within 30 days of receiving satisfactory proof of claim; the limitation period for commencing an action to recover life insurance proceeds is generally the earlier of 2 years after furnishing proof of claim or 6 years after the death; where order of death cannot be determined, the beneficiary is presumed to have died before the life insured; in cases of competing claims or disputes, the insurer may apply to pay the proceeds into court to obtain a full discharge.

Presumption of death: exam standard versus BC statutory differences	presumption of death	The standard exam standard uses 7 years of unexplained absence as the threshold to apply for a declaration of presumption of death, whereas section 3 of the British Columbia Presumption of Death Act requires only three conditions: no contact, no reason to believe the person is alive, and reasonable grounds to believe the person is dead, with no fixed statutory waiting period.

Self-test cues (Cornell left column)

1. Which policy changes qualify as purely administrative changes, and which changes require submitting fresh evidence of insurability for underwriting?
2. What are the fundamental differences in eligibility conditions between the 30-day grace period, the 30-day short reinstatement window, and the 2-year long reinstatement window?
3. How do revocable and irrevocable beneficiary designations differ regarding formalities, head office filing requirements, and alteration rights?
4. What are the legal consequences of divorce, verbal notice to an insurance agent, or holding a power of attorney for property (POA) on existing policy beneficiary designations?
5. When settling claims involving age misstatements, simultaneous deaths, competing claimants, or disappearance, how do standard exam answers and BC statutes resolve each scenario?

Summary: In three sentences, summarize the core post-issue rules governing underwriting thresholds for policy changes, the grace period and two-tier reinstatement windows, beneficiary formalities, and statutory claim adjustments, highlighting where standard exam answers diverge from BC provincial legislation.

Chapter 13 · What Accident and Sickness Insurance Protects: Financial Goals and Four Risk Categories for Individuals, Families, and Businesses

Accident & Sickness | P2 Hold steady | Financial Protection · 4 mock questions

Read with these questions: Between declining business customer orders and an owner's severe illness halting work, which risk is covered by A&S insurance?; For a non–work–related short–term disability, how many weeks of federal EI sickness benefits are calculated under the exam standard?; Worrying about routine prescription drugs draining savings versus worrying about long–term care fees exhausting an estate: which insurance product solves each concern?; Why does an owner using personal critical illness insurance payouts to pay commercial rent and employee wages create serious financial risks?

How it is tested

- Scenario–matching questions (financial goals x four risk categories): Given an unexpected event for a family or individual (such as premature death, a short–term fracture, a cancer diagnosis, or needing care in old age), tests identifying which risk category it belongs to, which financial goal it impacts (wealth accumulation, retirement income, or daily family needs), and distinguishing general mortality risk (life insurance) from accidental death coverage (AD&D).
- Needs classification and product–matching questions (four core needs): Given what the client wants to protect (monthly cash flow, routine savings, accumulated assets or estate, or business overhead expenses), tests distinguishing protecting income (DI), protecting savings (extended health, dental, and travel insurance), protecting assets (CI and LTC), and protecting business (BOE, key person insurance, or buy–sell disability insurance).
- Multi–source benefit order and coordination questions (first payor rule): Given a work–related or non–work–related, short–term or long–term disability scenario, tests determining whether government programs (workers' compensation, EI sickness benefits, CPP–D, provincial health coverage) or group/individual private insurance pay first, which fills the gap, and why multiple benefit sources cannot simply be added together.
- Business risk and management strategy distinction questions: Given operational challenges or health shocks faced by small and medium–sized business owners, tests distinguishing systematic risk (market and economic fluctuations, not covered by A&S) from unsystematic risk (business–specific risks such as owner health, coverable by A&S), and applying the four risk management techniques (avoidance, reduction, retention, and transfer).
- Exam standard and dual–benchmark numerical questions: Focusing on EI sickness benefit weeks (exam standard of 15 weeks vs. current 26 weeks), workers' compensation wage–loss replacement ratio (exam standard of 80% to 90%), and CPP–D qualification criteria (severe and

Traps (watch for the signal)

Confusing disability and critical illness claim triggers: The question stem describes a client diagnosed with a severe illness who can still work remotely or part–time, or a client temporarily unable to work due to back pain or a fracture without meeting any covered critical illness definition.

Simply adding multiple benefit sources together: The question stem lists two or more income replacement sources (such as mentioning both workers' compensation and EI, or group LTD and CPP–D), asking how much the client actually receives or which pays first.

Confusing protecting savings with protecting assets: The question stem compares routine non–government–covered prescription drug and physiotherapy expenses with needing to liquidate retirement investments or real estate to pay for critical illness recovery or long–term care costs.

Using personal critical illness insurance for business overhead: The question stem features a small business owner or self–employed person who worries about both home mortgage living costs and paying commercial rent and employee wages during an illness or disability.

Dual–benchmark confusion on EI sickness benefit weeks: The question stem involves a non–work–related short–term disability, asking for the maximum weeks covered by EI sickness benefits, or calculating the government benefit duration before group LTD starts.

prolonged), tests answering according to the exam standard in the exam room and identifying timeline gaps.

Mind map



Chapter 13Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Financial goals and four risk categories matrix	financial goals and four risk categories (mortality, disability, illness, longevity)	Individuals and families pursue three primary financial goals—wealth accumulation, retirement income, and daily family needs—which are threatened by four risk categories: mortality, disability, illness, and longevity; premature death from any cause is primarily covered by life insurance, while AD&D in A&S covers only accidental death.
Nature of longevity risk	longevity risk	Longevity risk refers to outliving accumulated assets and savings; it is the only one among the four risk categories that appears positive on the surface, but financially threatens retirement accumulation, erodes the estate, or shifts long-term care costs onto family members.
Systematic and unsystematic business risks	systematic risk vs. unsystematic risk (business risk)	Systematic risks, such as interest rate fluctuations and industry economic cycles, fall outside the scope of A&S insurance; health impairment of an owner or key employee is an unsystematic (business-specific) risk that can be managed through a combination of risk retention (self-funding) and insurance coverage.
Dual-benchmark rules for EI sickness benefits	Employment Insurance (EI) sickness benefits	EI sickness benefits replace 55% of insurable earnings; the exam standard provides a maximum benefit period of 15 weeks (after a one-week waiting period, with an earlier maximum of $638 per week), whereas the 2026 current rule provides up to 26 weeks (maximum $729 per week); candidates must follow the exam standard and specific question stems on the exam.
CPP disability benefit qualification and commencement	CPP disability benefit (CPP-D)	Qualifying for CPP-D requires being under age 65, meeting contribution criteria (generally 4 of the last 6 years, or 3 of the last 6 years with at least 25 years of contributions), and having a disability that is severe and prolonged; benefits typically begin four months after the month ESDC determines the severe and prolonged disability started.
Workers' compensation and first payor rule	Workers' Compensation and first payor rule	When coordinating multiple benefit sources, determine the triggering cause first: workplace injuries or occupational diseases are covered primarily by workers' compensation (exam standard replaces 80% to 90% of net earnings; BC WorkSafeBC pays about 90%), and the claimant usually does not receive EI; each source must be separately reviewed for all-source maximum limits and offset clauses.
Four risk management techniques	risk avoidance, reduction, retention, and transfer	Risk management comprises avoidance (refraining from high-risk activities), reduction (health management and safety training), retention (emergency savings and lengthening waiting periods), and transfer (purchasing A&S insurance); advisors should evaluate the first three techniques before determining the amount of risk to transfer.
Four A&S need categories and product mapping	protecting income, savings, assets, and business	The four A&S need categories are: protecting income (individual and group DI), protecting savings (extended health, dental, and travel insurance), protecting assets (critical illness insurance CI and long-term care insurance LTC), and protecting business (business overhead expense BOE, key person insurance, and buy-sell disability insurance).
Four-level spectrum of disability definitions	own occupation, regular occupation, any occupation, CPP total disability	The standards defining an inability to work range from most liberal to most restrictive across four levels: own occupation -> regular occupation -> any occupation -> CPP total disability; the further along the spectrum, the higher the threshold required to qualify for benefits.
Government benefit boundaries for self-employed and platform workers	self-employed EI special benefits and platform workers coverage	Self-employed individuals are excluded by default from EI special benefits and must register voluntarily and usually wait 12 months before claiming; however, British Columbia has included app-based ride-hail and delivery platform workers under the WorkSafeBC workers' compensation system effective September 3, 2024.

Self-test cues (Cornell left column)

1. When three family financial goals face mortality, disability, illness, and longevity risks, why is a general premature death gap not addressed by A&S insurance?
2. What is the difference between systematic and unsystematic risks for business owners, and which one can A&S insurance transfer?
3. Across workplace injuries, non-work-related short-term disabilities, non-work-related severe long-term disabilities, and routine medical costs, which pays first between government and private insurance?
4. Which specific insurance products correspond to the four A&S need categories: protecting income, protecting savings, protecting assets, and protecting business?
5. What dual-benchmark differences exist between the exam standard and current BC rules regarding EI sickness benefit weeks, workers' compensation replacement ratios, MSP, and CPP-D?

Summary: In three sentences, summarize how an advisor first identifies gaps using the financial goals by four risk categories matrix, deducts the government first-payor tier (workers' compensation, EI, CPP-D, MSP), and matches the remaining needs to the four A&S product categories (protecting income, savings, assets, and business).

Chapter 14 · Disability Insurance (DI): Income Replacement, Coordination of Group, Individual, and Government Benefits

Accident & Sickness | P1 Must score | Disability Income · 3 mock questions

Read with these questions: If a group disability policy specifies an own occupation definition, can an employee still collect full benefits after transferring to another role?; When the exam asks for the maximum benefit weeks for EI sickness benefits, should you answer 15 weeks or 26 weeks?; After CPP disability benefits are approved, how much will group LTD be reduced under an 85% all-source maximum?; When a relapse from the same cause occurs after returning to work for 4 months, how are the waiting period and remaining benefit period calculated?

How it is tested

- Disability definition and renewability classification questions: Given an insured's return to work or job transfer after disability, tests whether benefits continue under the four disability definitions (own occupation, regular occupation, any occupation, and CPP total disability), or tests whether the insurer can unilaterally raise premiums, alter policy terms, or cancel coverage under the three renewability provisions (non-cancellable, guaranteed renewable, and cancellable).
- All-source maximum and multi-benefit offset calculation questions: Given pre-disability gross monthly income, group long-term disability (group LTD), CPP disability benefits (CPP-D), and individual disability insurance amounts, tests calculating the net reduced group benefit under the master contract's all-source maximum (typically 85%).
- Waiting period and benefit period independent cap calculation questions: Given the waiting period, benefit period, and actual months of continuous disability, tests calculating payable claim months where the waiting period and benefit period do not offset each other and the benefit period cap applies first.
- Recurring disability clause time-window distinction questions: Given the initial benefit months, months returned to work, and subsequent relapse from the same cause, tests distinguishing whether relapses within the recurring disability window (typically 6 months) waive the waiting period while combining against the remaining benefit period, or whether relapses outside the window require a fresh waiting period and reset the benefit period.
- Exam standard and current policy dual-benchmark questions: Tests the maximum benefit weeks for federal Employment Insurance (EI) sickness benefits (exam standard of 15 weeks vs. current 26 weeks) and the medical underwriting waiver under group-to-individual conversion privileges.

Traps (watch for the signal)

Confusing group and individual own occupation definitions: The question stem mentions both group plan / group LTD and own occupation, and describes a job transfer or engaging in other gainful work.

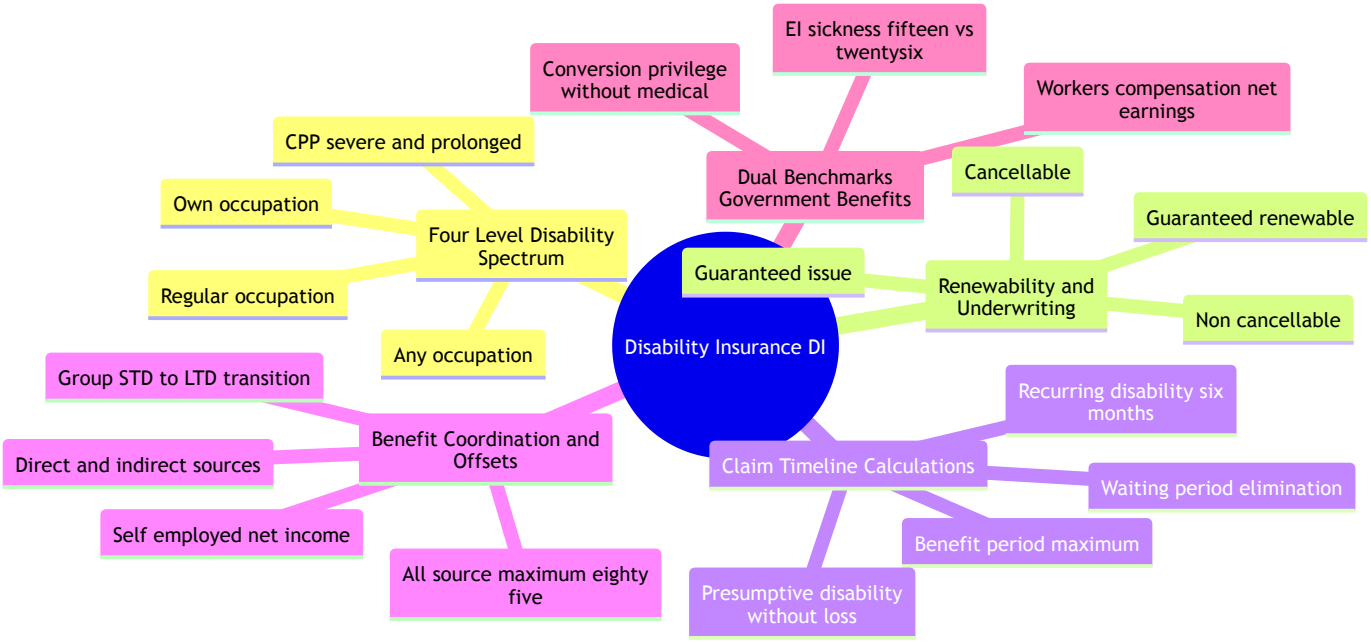
Offsetting waiting period and benefit period against each other: The question stem provides three time figures simultaneously: the waiting period (such as 90 or 120 days), the benefit period (such as 2 or 5 years), and total disability duration.

Remembering waived waiting period but forgetting combined benefit cap under recurring disability: The question stem features a relapse from the same cause and specifies the exact number of months returned to work between disabilities (such as 4 months or 7 months).

Overlooking master contract terms in all-source maximum or treating government benefits as unreduced extra income: The question stem provides pre-disability gross income, group disability benefit percentage, CPP-D amount, and the all-source maximum (such as 85%).

Failing to deduct operating expenses or including passive income in self-employed insurable earnings: The question stem features a self-employed individual and lists gross business revenue, operating expenses, and ongoing rental or investment income.

Mind map


Disability Insurance DI
Four Level Disability Spectrum
CPP severe and prolonged
Own occupation
Regular occupation
Any occupation
Dual Benchmarks Government Benefits
Conversion privilege without medical
EI sickness fifteen vs twentysix
Workers compensation net earnings
Guaranteed issue
Renewability and Underwriting
Cancellable
Guaranteed renewable
Non cancellable
Benefit Coordination and Offsets
Group STD to LTD transition
Direct and indirect sources
Self employed net income
All source maximum eighty five
Claim Timeline Calculations
Recurring disability six months
Waiting period elimination
Benefit period maximum
Presumptive disability without loss

Chapter 14Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Four disability definitions from most liberal to most restrictive	definition of disability (own occupation, regular occupation, any occupation, CPP total disability)	Individual own occupation allows working in another occupation with unreduced benefits; regular occupation (and group own occupation) reduces or stops benefits upon returning to work; any occupation ceases benefits if the insured can perform any work commensurate with education, training, or experience; CPP total disability requires the disability to be both severe and prolonged.
Three renewability provisions and conversion at age 65	non-cancellable, guaranteed renewable, and cancellable policies	Non-cancellable policies lock in premiums and terms with no unilateral cancellation and typically permit medical-free conversion to guaranteed renewable at age 65; guaranteed renewable policies cannot be cancelled but allow class-wide premium increases; cancellable policies may be terminated unilaterally by the insurer.
Individual insurable income ratio and self-employed earnings baseline	insurable income and net business income	Under the exam standard's industry practice, individual disability insurance generally covers no more than 60% to 66.66% of gross earned income; self-employed individuals must calculate coverage using net business income (gross revenue minus operating expenses), while ongoing passive income is listed separately and excluded from insurable earned income.
Dual benchmarks for Employment Insurance sickness benefits	Employment Insurance (EI) sickness benefits	The exam standard provides EI sickness benefits for up to 15 weeks following a one-week waiting period (55% income replacement, 2022 cap of $638 per week), whereas current policy provides up to 26 weeks (cap of $729 per week); candidates answer 15 weeks on the exam unless specific new figures are given.
Group conversion privilege without medical underwriting	conversion privilege	Upon terminating group plan membership, an employee can convert group coverage into an individual disability policy within a short window (stated as 30 days or 31 days across different chapters of the exam material; governed by the master contract in practice) without providing evidence of insurability.
Group all-source maximum and offset mechanisms	all-source maximum (group offset)	A group master contract typically stipulates that total benefits from all direct and indirect sources cannot exceed 85% of pre-disability gross income (typical exam value); any excess directly reduces group disability payments, and whether individual policies are included depends on the master contract terms.
Independence of waiting period and benefit period	waiting period (elimination period) and benefit period	The waiting period is the interval from disability onset to the start of payments, while the benefit period is the maximum duration payable; they do not offset each other, and payable months must be capped by the benefit period limit first.
Window effects of the recurring disability clause	recurring disability clause	A relapse from the same cause within the designated window (typically 6 months under the exam standard) after disability ends is treated as the same disability, waiving a new waiting period but combining against the original benefit period cap; relapses beyond the window require a fresh waiting period and reset the benefit period.
Timing of definition changes in group disability plans	change of definition (from own/regular occupation to any occupation)	Under typical group long-term disability (LTD) structures, the definition shifts from own or regular occupation to any occupation only after LTD benefits have been paid for a specific period (such as 12 months of LTD, which is the start of Month 25 following a 12-month STD period).
Presumptive disability without proof of income loss	presumptive disability	When the insured suffers a specified severe and permanent impairment listed in the policy, total disability benefits are payable without requiring proof of income loss or inability to work, even if the insured continues working at full salary.

Self-test cues (Cornell left column)

1. How are the four disability definitions ranked from most liberal to most restrictive, and which tier does group own occupation actually operate under?
2. How do the three renewability provisions—non-cancellable, guaranteed renewable, and cancellable—differ regarding premium adjustment and cancellation rights?
3. How does an 85% all-source maximum calculate the reduction in group disability benefits, and what difference does including or exempting individual DI make?

4. When the waiting period, benefit period, and 6-month recurring disability window are placed on a single timeline, how do you calculate the remaining payable months?
5. What dual-benchmark differences exist between the exam standard and 2026 practice regarding EI sickness weeks and group conversion privilege windows?

Summary: In three sentences, summarize the three core steps of disability claim adjudication: first determine claim eligibility under policy definitions, next calculate payable duration using the waiting period, benefit period, and recurring window, and finally determine net monthly benefits using the all-source maximum and master contract offset rules.

Chapter 15 · Critical Illness & Long-Term Care Insurance

Accident & Sickness | P1 Must score | Critical Illness & LTC · 3 mock questions

Read with these questions: How does the payout outcome differ if the insured dies before versus after completing the survival period following a critical illness diagnosis?; How many days is the LTC elimination period under general exam rules compared with current market products?; Why is coverage denied for a colloquial mini-stroke (TIA) or when a second illness occurs without a second event rider?; When daily LTC care costs are below the daily cap, can the remaining balance carry forward for future use?

How it is tested

- Scenario qualification questions: Presenting acute clinical symptoms or an initial diagnosis (such as a transient ischemic attack or an early-stage lesion), testing whether you can recognize that claim eligibility depends strictly on contractual definitions rather than everyday disease names.
- Time-gate discrimination questions: In scenarios where a diagnosis occurs shortly after policy inception or death occurs shortly after diagnosis, testing the starting points and legal consequences of the qualification period versus the survival period.
- Benefit calculation and carry-forward questions: Providing a partial benefit percentage for critical illness (such as 35%), or a daily maximum benefit, actual daily expenses, and total benefit pool for long-term care, testing your ability to calculate the actual claim payout or the extended days available from the carried-forward benefit pool.
- Second-event claim and policy continuation questions: A client previously received a full critical illness payout or an early partial benefit and suffers a second critical illness years later, testing whether the original policy terminated and the applicable conditions of a second event rider.
- Dual-standard and product mechanics questions: Testing the two trigger criteria for long-term care insurance—the six activities of daily living (ADLs) or cognitive impairment—the elimination period (0 to 90 days under the exam rule), and standard rules for home care reimbursement versus facility care indemnity.

Traps (watch for the signal)

Confusing qualification period with survival period: The question stem presents symptoms discovered shortly after policy issue or reinstatement, or outlines a timeline where the insured dies on day N following diagnosis.

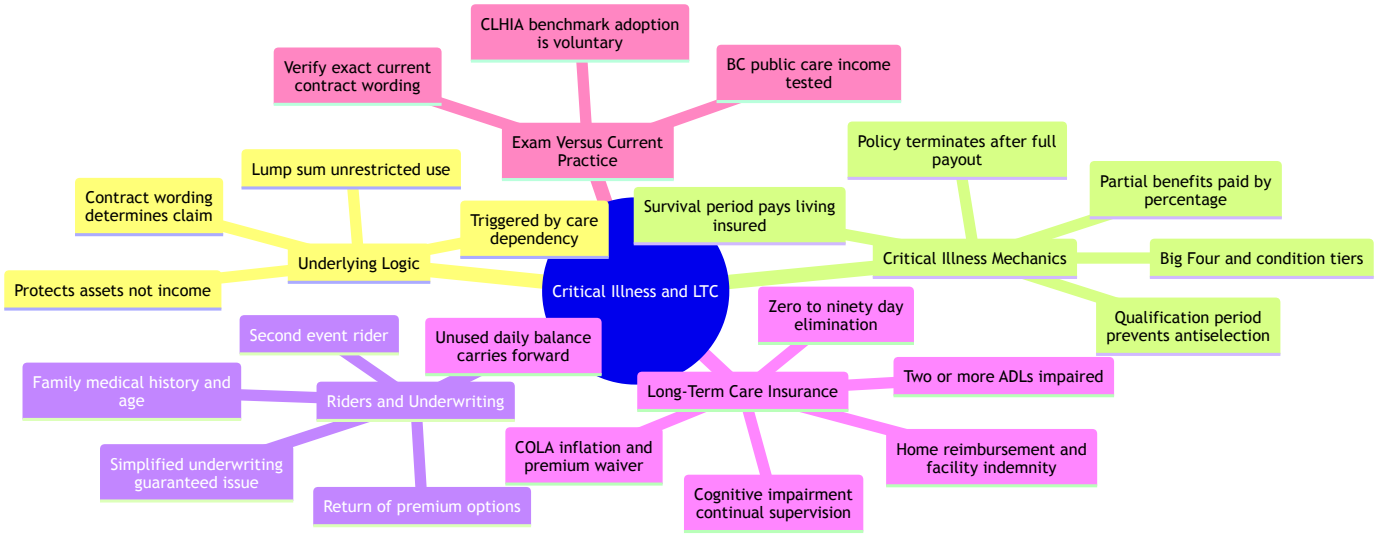
Determining claims based solely on colloquial disease names: The question stem highlights symptoms resolving completely within a short time, imaging showing no permanent impairment, or specifies the physician's precise clinical diagnostic abbreviation.

Assuming critical illness always pays in full or continues indefinitely: The question stem specifies a condition paying a fixed percentage (such as 35%), or notes that the client received a 100% full critical illness payout years earlier without purchasing a rider.

Overlooking the carry-forward of unused daily LTC benefits: The question stem provides the daily maximum benefit, nominal days (or total maximum benefit pool), and an actual daily care invoice lower than the daily maximum.

Treating current market details as general exam rules: The question stem asks about the typical LTC elimination period range, the general classification of home versus facility care models, or whether critical illness definitions are legally mandated across insurers.

Mind map


Critical Illness and LTC
Exam Versus Current Practice
CLHIA benchmark adoption is voluntary
Verify exact current contract wording
BC public care income tested
Underlying Logic
Lump sum unrestricted use
Contract wording determines claim
Triggered by care dependency
Protects assets not income
Critical Illness Mechanics
Survival period pays living insured
Policy terminates after full payout
Partial benefits paid by percentage
Big Four and condition tiers
Qualification period prevents antiselection
Long-Term Care Insurance
Zero to ninety day elimination
Two or more ADLs impaired
Home reimbursement and facility indemnity
Cognitive impairment continual supervision
COLA inflation and premium waiver
Riders and Underwriting
Second event rider
Unused daily balance carries forward
Family medical history and age
Simplified underwriting guaranteed issue
Return of premium options

Chapter 15Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Asset protection purpose	critical illness (CI) / long-term care (LTC) insurance	Critical illness (CI) and long-term care (LTC) insurance protect depleted assets rather than replacing lost earned income; CI typically pays a lump-sum benefit with no restrictions on how the funds are used.
Distinction between qualification period and survival period	qualification period / survival (waiting) period	The qualification period runs from policy issue or reinstatement (commonly 30 or 90 days) to prevent anti-selection; the survival period runs from diagnosis or surgery (commonly 30 or 90 days), where dying before completing the survival period yields no CI benefit, but dying after satisfying the survival period and before claim approval still pays the benefit.
The Big 4 core conditions and product tiers	"Big 4" conditions	Under exam rules, the Big 4 core critical conditions are heart attack, stroke, cancer, and coronary artery bypass surgery; market products commonly range from basic 3- or 4-condition plans to 10-condition plans and comprehensive plans covering 20 or more conditions.
Industry critical illness benchmark definitions	CLHIA CI Benchmark Definitions	The CLHIA CI Benchmark Definitions have evolved through 2013, 2018, and 2024 versions, but adoption by insurance companies is entirely voluntary, meaning claim adjudication requires verifying the exact wording in the specific policy contract.
Dual benefit triggers for LTC	activities of daily living (ADLs) / cognitive impairment test	Long-term care insurance claims typically require the inability to perform at least 2 of the 6 activities of daily living (ADLs: dressing, bathing, toileting, transferring, eating, and continence) independently, or satisfying the cognitive impairment test requiring continual supervision.
Dual standard for LTC elimination periods	elimination period (LTC)	The exam describes the long-term care elimination period as an optional 0 to 90 days (shorter periods mean higher premiums), whereas individual products sold today can have waiting periods of 365 or 730 days and require satisfying a coverage effective date threshold first.
Dual framework for BC care costs	long-term care (LTC) insurance	The exam only lists an outdated monthly fee range for unsubsidized private facilities ($995 to $3,500), whereas 2026 BC publicly subsidized facilities assess monthly fees at 80% of after-tax income (standard minimum $1,507.70, maximum $4,142.60).
Full CI claim termination and second event rider	second event rider / partial benefit	A traditional critical illness policy terminates upon paying a 100% full claim, and subsequent conditions are not covered without a second event rider; however, partial benefits (such as a 35% payout or early-stage condition payout) do not necessarily terminate the base coverage.
LTC payment models and balance carry-forward	indemnity model / reimbursement model / daily maximum benefit	General exam rules categorize home care under an expense reimbursement model and facility care under an indemnity model; in reimbursement policies deducting from an aggregate pool, when daily actual expenses are below the daily cap, the unused balance carries forward to extend the benefit period.
Inflation protection and return of premium riders	cost-of-living adjustment (COLA) / return of premium (ROP) rider	LTC policies can offset inflation through a COLA rider (with exam examples showing a 2% to 3% annual cap increase) and automatically waive premiums during claim periods; CI policies can refund partial or full premiums upon death, surrender, or maturity without claims via an ROP rider.

Self-test cues (Cornell left column)

1. What is the fundamental difference in protection goals between critical illness (CI) and long-term care (LTC) insurance versus disability insurance (DI)?
2. When do the qualification period and survival period each begin, and how is the benefit handled if the insured dies after completing the survival period but before the payout is issued?
3. Why is a condition colloquially termed a mini-stroke (TIA) denied under a critical illness policy that excludes it, and are condition definitions uniform across different insurers?
4. What are the six ADLs in long-term care insurance, and how does the exam elimination period range differ from products currently sold on the market?
5. When actual daily LTC reimbursement is lower than the contractual daily maximum, what impact does it have on the total benefit period, and what happens to a CI policy after a full claim payout?

Summary: Summarize in three sentences: how critical illness and long-term care insurance determine eligibility and payout amounts through precise contract definitions, dual time gates (qualification and survival periods), and daily maximum benefit pool rules, and highlight one key dual-standard difference between general exam rules and the current 2026 market.

Chapter 16 · Extended Health, Dental, and Travel Insurance

Accident & Sickness | P2 Hold steady | Health, Dental & Travel · 2 mock questions

Read with these questions: How is a claim calculated when both a deductible and a co-insurance factor apply?; When a dentist charges more than the fee schedule, does the excess difference count as a claim denial?; If medication was adjusted during the stability period, is an accidental broken leg covered during the trip?; Does accidental dismemberment under an AD&D policy always pay 100% of the principal sum upon injury?

How it is tested

- Expense-sharing calculation questions: Presenting an annual deductible and a co-insurance factor simultaneously, testing whether you strictly follow the two-step sequence of subtracting the deductible first before applying the percentage to the remaining balance, as well as the sequential clearing rules governing whether the individual deductible or family deductible is satisfied first.
- Dental and prescription drug reimbursement boundary questions: Presenting scenarios where a dentist charges above the fee schedule or a client insists on a brand-name drug outside the formulary, testing your understanding that paying the out-of-pocket difference arises from non-covered excess charges rather than an insurer breach or claim denial.
- Travel insurance pre-existing condition and stability period questions: Providing the timeline of medication adjustments, follow-up exams, or symptom emergence prior to departure for seniors or chronic condition patients, testing the retrospective determination of the stability period and confirming that denying a claim for a pre-existing condition does not void unrelated accidental injury claims on the same trip.
- Group benefits gap and needs analysis questions: Identifying coverage shortfalls in an employer group package regarding vision care, orthodontics, hospital room upgrades, accidental death and dismemberment (AD&D), or out-of-country travel, testing how to retain the existing group plan while precisely filling identified gaps with individual coverage.
- Tax treatment and interprovincial exception questions: Evaluating the non-taxable employment benefit treatment under federal tax law for employer-paid premiums toward a qualifying private health services plan (PHSP), testing that Quebec's provincial tax exception must not be erroneously applied to other provinces or federal taxation.

Traps (watch for the signal)

Reversing the calculation order of deductible and co-insurance: The question stem presents the total bill, an annual deductible, and a co-insurance factor simultaneously.

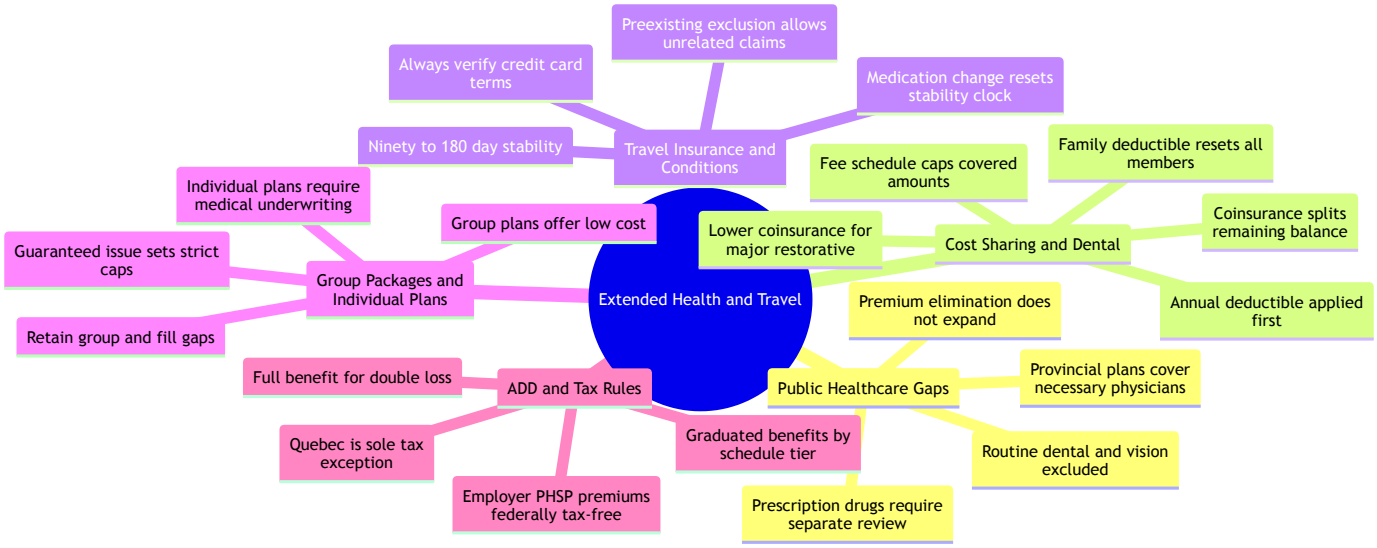
Mistaking charges exceeding the fee schedule for claim denial: The question stem states that the dental clinic's actual charges exceed the provincial dental association fee guide or the fee schedule specified in the contract.

Overextending pre-existing condition exclusions to unrelated claims: The question stem describes a medication adjustment or medical visit during the stability period, followed by a sudden accident or new medical claim completely unrelated to the pre-existing condition.

Replacing group benefits with individual insurance to fill gaps: The question stem asks how to address coverage shortfalls through needs analysis when an employer group extended health plan lacks specific benefits.

Assuming full AD&D payouts or confusing interprovincial tax rules: The question stem specifies accidental loss of a single limb, one eye, or one ear, or asks about the tax consequences of employer-paid PHSP premiums in British Columbia.

Mind map


Extended Health and Travel
Travel Insurance and Conditions
Preexisting exclusion allows unrelated claims
Always verify credit card terms
Medication change resets stability clock
Ninety to 180 day stability
Group Packages and Individual Plans
Individual plans require medical underwriting
Group plans offer low cost
Guaranteed issue sets strict caps
Retain group and fill gaps
Cost Sharing and Dental
Fee schedule caps covered amounts
Family deductible resets all members
Lower coinsurance for major restorative
Coinsurance splits remaining balance
Annual deductible applied first
Public Healthcare Gaps
Premium elimination does not expand
Provincial plans cover necessary physicians
Routine dental and vision excluded
Prescription drugs require separate review
ADD and Tax Rules
Full benefit for double loss
Quebec is sole tax exception
Graduated benefits by schedule tier
Employer PHSP premiums federally tax-free

Chapter 16Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Scope of provincial healthcare and extended health coverage	provincial health care plans / extended health insurance	Provincial healthcare plans primarily cover medically necessary physician and hospital services; routine dental care, routine eye exams for adults aged 19 to 64, paramedical services, and out-of-country balances must be evaluated against public and existing private plans and supplemented through extended health insurance.
Calculation sequence for deductible and co-insurance	deductible and co-insurance factor	When adjudicating eligible medical or dental claims, the unused annual deductible must be subtracted first before multiplying the remaining balance by the co-insurance factor to determine the insurer's reimbursement.
Coordination between individual and family deductibles	individual deductible and family deductible	Family members accumulate their own individual deductibles, but once the eligible deductible expenses incurred across all family members reach the family deductible cap, the deductible requirement is satisfied and cleared for all family members for the remainder of the year.
Dental tiers and fee schedules	fee schedule / routine maintenance vs. major restorative	Co-insurance for routine maintenance is commonly 75% to 80%, while major restorative work typically drops to 50%; reimbursement is capped by the fee schedule adopted in the contract, and any excess charged by the dentist above the fee schedule is an out-of-pocket expense for the insured rather than a claim denial.
Travel insurance pre-existing conditions and stability periods	pre-existing condition and stability period	Under exam rules, the look-back stability period for pre-existing conditions is typically 90 to 180 days prior to departure (chronic conditions may require a full year of continuous stability for full coverage); medication adjustments during the stability period result in denial of claims related to that pre-existing condition, but do not affect unrelated accidental injury claims provided there was no material misrepresentation.
Verification of credit card travel insurance	credit card travel insurance	Both credit card travel insurance and standalone travel policies require verifying cardholder status, age limits, trip duration caps, stability periods, and certificate of insurance terms; the absence of a lengthy medical questionnaire at purchase does not waive medical record verification at the time of claim.
Group package gaps and individual customization	group package vs. individual customization / needs analysis	Group plans provide one-size-fits-all packages with the advantages of lower premiums and non-underwritten coverage; when addressing shortfalls such as missing AD&D, low vision limits (e.g., $100 every 24 months), or low orthodontic maximums, advisors should retain the group plan and precisely supplement the gaps using individual plans.
Mechanics of guaranteed issue personal health plans	guaranteed acceptance / guaranteed issue plan	Guaranteed acceptance or guaranteed issue plans require no medical questionnaire at application and accommodate individuals who face underwriting hurdles, but they typically carry higher premiums and impose separate waiting periods and tighter sub-limits on prescription drugs, medical equipment, and travel durations.
Accidental death and dismemberment graduated schedule of loss	accidental death and dismemberment (AD&D) / schedule of loss	AD&D benefits are paid according to a graduated schedule of loss rather than paying the full principal sum for every event: loss of two limbs, sight in both eyes, or death pays 100%, while loss of one limb or sight in one eye is commonly illustrated at 75% or 67%, speech at 50%, and hearing in one ear at 33%, provided the loss occurs within the contractual time limit (illustrated as 365 days on the exam).
Tax treatment of employer PHSP premiums	private health services plan (PHSP) taxable benefit	Under federal income tax rules, employer-paid premiums for a qualifying private health services plan (PHSP) generally do not constitute a taxable benefit to employees; Quebec provincial tax is the sole exception treating employer contributions as taxable, while British Columbia follows the general federal rule.

Self-test cues (Cornell left column)

1. Why does a service being excluded from provincial health care not equate to zero government support?
2. What is the two-step sequence for calculating a claim payout when both a deductible and a co-insurance factor apply?
3. Why is a reduced payout due to dental charges exceeding the fee schedule not considered a claim denial by the insurer?

4. If a traveller adjusts their heart medication dosage during the stability period, can they still claim for a broken leg suffered on the trip?
5. What is the standard procedure in needs analysis when an employer group extended health plan has coverage gaps?

Summary: Summarize in three sentences: the boundary between public healthcare and private extended health coverage, the sequential deduction rules for deductibles, co-insurance, and fee schedules during claim settlement, and the core rules governing travel insurance stability periods and supplementing group benefit gaps.

Chapter 17 · Business Disability Insurance: BOE, Key Person Disability, and Disability Buyout

Accident & Sickness | P3 Skim | Business A&S · 1 mock questions

Read with these questions: When a business owner is temporarily disabled, which expense can never be reimbursed under business overhead expense (BOE) insurance?; What inverse rules govern premium deductibility and benefit taxation between business overhead expense (BOE) and business loan protection disability insurance?; To whom are key person disability insurance benefits paid, and what is the typical maximum benefit period?; When a 62-year-old partner triggers disability buyout insurance, how does the 20% annual post-age-60 reduction affect the available coverage?

How it is tested

- Scenario-matching questions: Given the disability impacts faced by a sole proprietorship, partnership, or closely held corporation (disrupted fixed operating expenses, disability of a key employee, or exit of a disabled partner), test your ability to precisely distinguish the functional boundaries of business overhead expense (BOE) insurance, key person disability insurance, and buy-sell disability buyout insurance.
- BOE eligible expense filtering and carryover calculation questions: Given a set of monthly business expenses (rent, employee wages, owner's personal salary, commercial loan principal and interest, new equipment purchases) and a monthly benefit cap, test your ability to exclude ineligible items and apply the carryover provision to calculate the actual reimbursement for the month.
- Tax treatment contrast questions: Juxtaposing business overhead expense (BOE) insurance with business loan protection disability insurance, test your ability to determine which policy has tax-deductible premiums and taxable benefits versus non-deductible premiums and tax-free benefits, and whether both policies can claim against the same loan.
- Disability buyout and age reduction questions: Given a scenario involving a partner over age 60 who suffers a long-term total disability, test your ability to recognize the 12-to-24-month long waiting period, the strict disability definition (unable to perform regular occupation and not working at all), and the impact of a 20% annual benefit reduction after age 60 on the resulting buyout funding shortfall.
- Corporate supplementary benefits and dual-perspective analysis questions: Test your ability to distinguish the Private Health Services Plan (PHSP) deduction rules across self-employed versus employee branches, the transition from legacy Health and Welfare Trusts (HWT) to Employee Life and Health Trusts (ELHT), and the distinction between the exam's cited 1985 actuarial table data and modern underwriting practices.

Traps (watch for the signal)

BOE Eligible Expense Scope Confusion Trap: The question stem mingles the owner's personal salary, commercial loan principal, or new equipment purchases into a list of monthly business expenses.

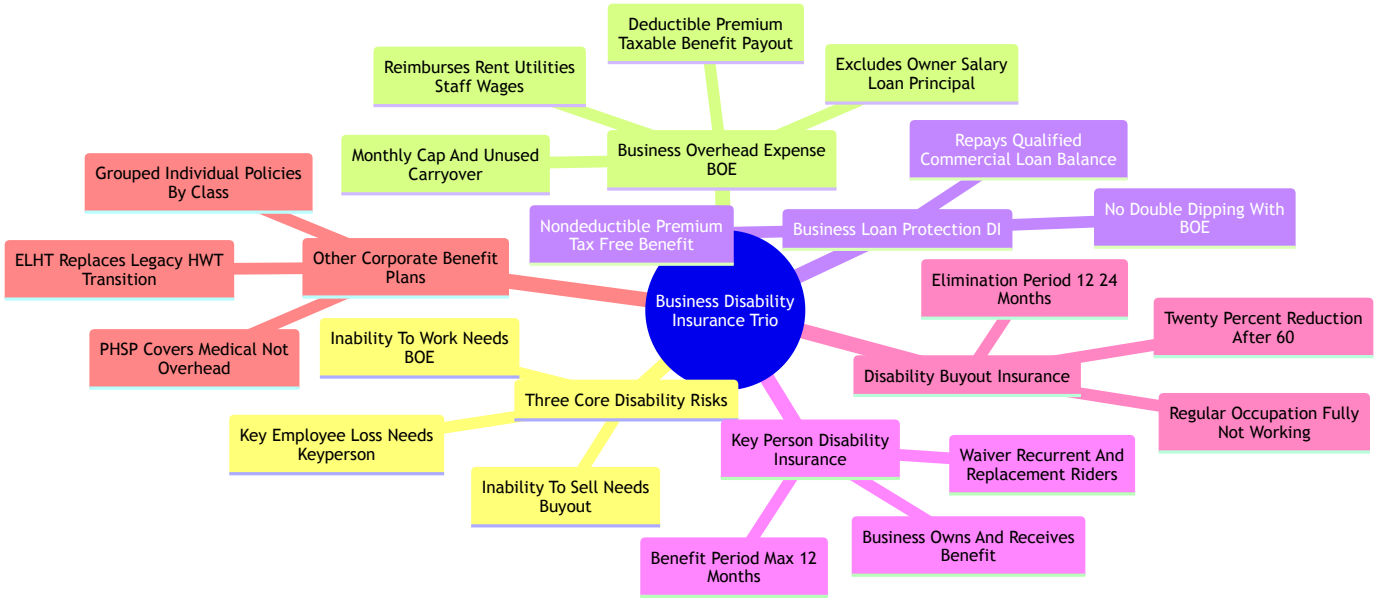
Tax Treatment Reversal Trap: The question stem presents both business loan protection disability insurance and BOE, asking whether premiums are tax-deductible or benefits are tax-free.

Beneficiary and Purpose Mismatch Trap: The question stem asks who the beneficiary of a key person disability policy is, or how to calculate the benefit amount needed for the replacement recruitment and training window.

Overlooking Post-Age-60 Reduction Trap: The question stem describes a partner over age 60 (such as age 62) triggering a buy-sell disability buyout provision and provides an initial policy face amount.

Disability Definition and Unfunded Agreement Trap: The question stem describes a disabled partner working part-time while seeking to trigger a buyout payout, or co-owners executing a legal agreement without arranging insurance funding.

Mind map


Business Disability Insurance Trio
Business Overhead Expense BOE
Deductible Premium Taxable Benefit Payout
Reimburses Rent Utilities Staff Wages
Excludes Owner Salary Loan Principal
Monthly Cap And Unused Carryover
Nondeductible Premium Tax Free Benefit
Business Loan Protection DI
Repays Qualified Commercial Loan Balance
No Double Dipping With BOE
Other Corporate Benefit Plans
Grouped Individual Policies By Class
ELHT Replaces Legacy HWT Transition
PHSP Covers Medical Not Overhead
Disability Buyout Insurance
Elimination Period 12 24 Months
Twenty Percent Reduction After 60
Regular Occupation Fully Not Working
Three Core Disability Risks
Inability To Work Needs BOE
Key Employee Loss Needs Keyperson
Inability To Sell Needs Buyout
Key Person Disability Insurance
Waiver Recurrent And Replacement Riders
Business Owns And Receives Benefit
Benefit Period Max 12 Months

Chapter 17Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Three Core Business Disability Risks and Policy Matching	inability to work / loss of key employee / inability to sell	An owner's temporary inability to work is covered by business overhead expense (BOE) insurance, the loss of a key employee is covered by key person disability insurance, and a disabled partner's exit requiring share monetization is covered by buy-sell disability buyout insurance; the three products cannot substitute for one another.
Disability Does Not Trigger Deemed Disposition Under Income Tax Act	deemed disposition on disability	When an insured becomes disabled, the individual remains living and equity does not automatically transfer, so disability does not trigger a death-related deemed disposition under the Income Tax Act; however, subsequent share sale or redemption still requires verifying tax liabilities and cash flow.
Business Owner Disability Risk Statistics from 1985 Table	1985 Commissioner's Disability Table statistics	Under exam conventions, the probability of a 45-year-old owner suffering a disability lasting over 90 days before age 65 is approximately 40%, the probability for at least one of two co-owners is approximately 62.5%, and the average duration is 3.2 years; candidates must answer based on these exam figures, though in practice they are never used as individual probability commitments.
Eligible vs. Ineligible Overhead Expenses for BOE	eligible vs. ineligible overhead expenses	Business overhead expense (BOE) insurance reimburses rent, utilities, employee wages, commercial loan interest, regular professional fees, and corporate insurance premiums; it strictly excludes the owner's personal salary, commercial loan principal repayments, capital expenditures for new equipment, and inventory purchases.
BOE Carryover Provision and Maximum Benefit Pool	carryover provision and maximum benefit pool	The total benefit pool equals the monthly limit multiplied by the maximum benefit period (commonly 15 to 24 months); unused monthly benefit amounts can carry over to reimburse eligible expenses in subsequent months exceeding the monthly limit, but unearned future limits cannot be borrowed in advance.
Tax Treatment Reversal of BOE vs. Business Loan Protection DI	tax treatment of BOE vs. business loan protection DI	Business overhead expense (BOE) premiums are tax-deductible as business operating expenses and benefits are taxable; business loan protection disability insurance premiums are non-deductible and benefits are tax-free, and both policies cannot duplicate claims on the interest of the same commercial loan.
Key Person Disability Insurance Parameters and Riders	key person disability insurance parameters and riders	Owned by and payable to the business, exam conventions cite common shareholding limits in the 10% to 50% range, waiting periods of 30 to 90 days, benefit periods generally not exceeding 12 months, and monthly caps around $15,000 (or 100% of annual salary); policies frequently include waiver of premium, recurrent disability clauses, and a replacement expense rider.
Core Mechanics of Buy-Sell Disability Buyout Insurance	disability buyout insurance provisions	Requires satisfying a strict composite definition of being unable to perform one's regular occupation and not working at all, features an extended elimination period of 12 to 24 months (commonly 360 days in current contracts), offers lump-sum or instalment payouts, and in exam examples reduces coverage by 20% per year after age 60.
PHSP Deduction Limits and ELHT Tax Transition	PHSP deduction limits and ELHT transition	Private Health Services Plans (PHSP) reimburse eligible medical expenses and, under specific self-employed provisions of Income Tax Act s.20.01, apply period-prorated deduction limits of $1,500 per adult and $750 per child under age 18; the administrative regime for legacy Health and Welfare Trusts (HWT) ended after 2021, and trusts not transitioned to ELHTs are taxed as ordinary trusts rather than forcibly dissolved.
Three-Layer Protection Framework for Business Owners	three-layer business owner protection	A comprehensive plan stacks three indispensable layers: business overhead expense (BOE) insurance to protect fixed business overhead, individual disability insurance or a grouped plan to replace the owner's personal income, and a Private Health Services Plan (PHSP) to cover routine out-of-pocket medical costs.

Self-test cues (Cornell left column)

1. Which three commercial disability insurance policies correspond to the three distinct disability risks faced by a business?
2. On a business overhead expense (BOE) reimbursement schedule, which items are eligible and which four typical expenses are strictly excluded?

3. Why is the income tax treatment of business overhead expense (BOE) insurance the exact inverse of business loan protection disability insurance?
4. How does key person disability insurance fundamentally differ from key person life insurance regarding beneficiary designation, benefit period, and coverage valuation logic?
5. What unique rules apply to buy–sell disability buyout insurance concerning waiting periods, disability definitions, and post–age–60 coverage reductions?

Summary: In three sentences, summarize the specific cash–flow pain points resolved by the business disability trio (BOE, key person disability, and disability buyout insurance), their respective beneficiary designations, and their core boundaries regarding tax treatment or age–related benefit reductions.

Chapter 18 · Client Profile: Income, Assets, Existing Coverage, and Gap Analysis

Accident & Sickness | P1 Must score | Client Profile · 7 mock questions

Read with these questions: If a self–employed client registered for EI special benefits less than 12 months ago is injured, can they claim? Can rental income count toward insurable earned income?; Under the exam benchmark, what is the maximum number of weeks of EI sickness benefits? How are the replacement rate and the RDSP contribution limit tested?; When tax–free group LTD is offset dollar–for–dollar by taxable CPP–D, does the after–tax gap grow or shrink once CPP–D is approved?; When sizing the disability gap for a dual–earner household, why can't you simply copy the theoretical difference left after subtracting the spouse's income?

How it is tested

- Scenario–based gap calculation questions: Given gross monthly earnings, group long–term disability (LTD) replacement percentage, premium payor, and effective tax rate, combined with government benefit direct offsets, calculate the true after–tax income replacement rate or the net monthly coverage gap.
- Employee versus self–employed comparison questions: Given the income structure of a freelancer or small business owner (including business operating expenses, dividends, or rental income) and an intent to apply for Employment Insurance (EI) special benefits, evaluate insurable earned income, the 12–month registration waiting period, and dual risk exposures.
- Financial tool and calculation methodology distinction questions: When a client faces premium budget constraints or needs to evaluate self–insurance capacity during an elimination period, correctly match between the income approach and expense approach, and between the net worth statement and cash flow statement.
- Dual–standard and government benefit rule questions: Test the differences between the exam benchmark (15 weeks) and current legislation (26 weeks) for Employment Insurance (EI) sickness benefits, the severe and prolonged disability criteria and benefit start month for Canada Pension Plan disability (CPP–D), and the lifetime contribution limit and grant repayment clawback rules for the Registered Disability Savings Plan (RDSP).
- Coverage adequacy four–scenario determination questions: After aggregating a client's existing group coverage, individual policies, and government benefits, compare against an all–source maximum (typically 85% of pre–disability gross income) to determine whether coverage is adequate, excessive, overlapping above the cap, or deficient, and select the compliant next step.

Traps (watch for the signal)

Net Versus Gross Income Confusion Trap: The question stem simultaneously mentions gross income, an effective tax rate (e.g., 25%), and employer–paid premiums or taxable CPP–D benefits.

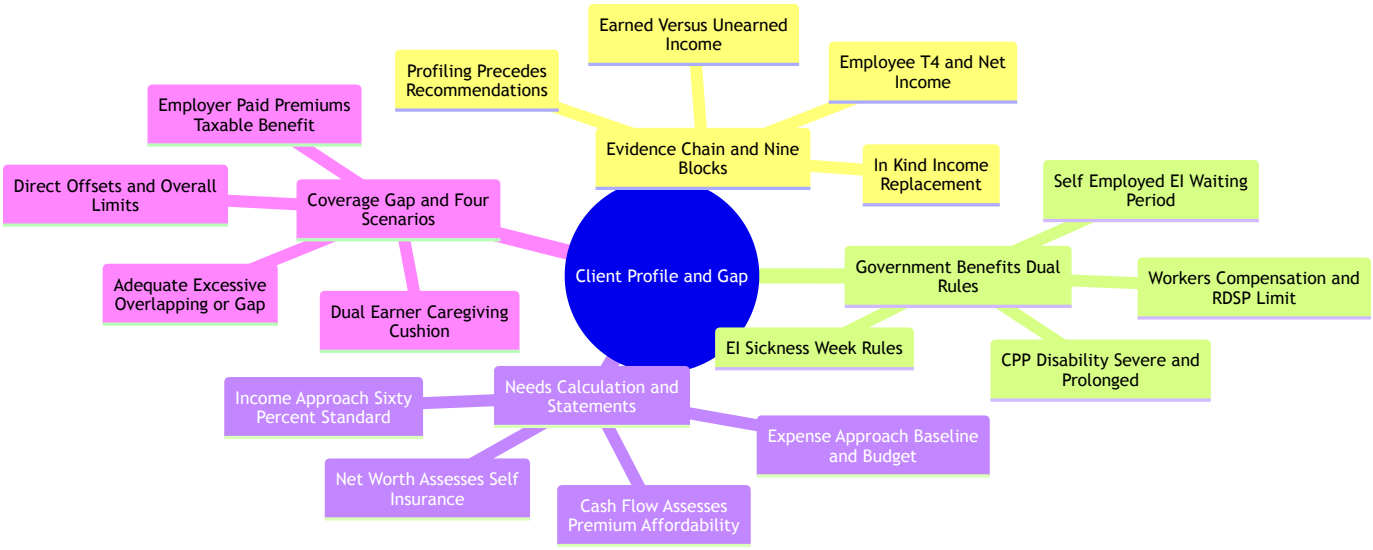
Mistaking Gross Business Revenue for Insurable Income Trap: The question stem mentions a self–employed individual, gross business revenue, operating expenses, passive investment income, or an MSCA registration under 12 months.

Overlooking Government Benefit Offsets and Assuming Guaranteed Approval Trap: The question stem mentions that the group master contract contains a direct offset clause, an 85% all–source maximum, or a newly submitted CPP–D application that has not yet been approved.

Mismatching Calculation Methodologies and Financial Statements Trap: The question stem highlights an affordability constraint, asks whether the client can self–insure through the elimination period, or asks which monthly expenses can be trimmed to afford premiums.

Conflating Exam Benchmarks with Current Legislation Trap: The question stem asks for the standard exam benchmark duration of EI sickness benefits (15 weeks vs. 26 weeks) or the 600–hour threshold, or involves a client resigning to start a business while expecting group LTD to continue.

Mind map


Client Profile and Gap
Evidence Chain and Nine Blocks
Earned Versus Unearned Income
Employee T4 and Net Income
In Kind Income Replacement
Profiling Precedes Recommendations
Coverage Gap and Four Scenarios
Employer Paid Premiums Taxable Benefit
Direct Offsets and Overall Limits
Adequate Excessive Overlapping or Gap
Dual Earner Caregiving Cushion
Government Benefits Dual Rules
Self Employed EI Waiting Period
Workers Compensation and RDSP Limit
EI Sickness Week Rules
CPP Disability Severe and Prolonged
Needs Calculation and Statements
Income Approach Sixty Percent Standard
Expense Approach Baseline and Budget
Net Worth Assesses Self Insurance
Cash Flow Assesses Premium Affordability

Chapter 18Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Client Profile and the Fact-Finding Discipline	Client profile & Fact-finding interview	Profiling must precede product recommendations and recommendations must precede contracts; all income, debts, and existing coverages must be verified using objective documentation such as tax returns, pay stubs, and group benefits booklets.
In-Kind Income and Household Replacement Value	In-kind income	Contributions from a stay-at-home caregiving spouse or community support do not generate direct cash flow, but their disability forces the household to incur replacement costs for outside caregiving; needs analyses must account for this economic value.
Self-Employed Insurable Income and EI Registration Rules	Self-employed insurable income & EI special benefits	A self-employed client's insurable earned income is verified from the net business income on the past two to three years of tax returns (excluding passive rent or dividends); furthermore, claiming EI special benefits requires voluntary registration for at least 12 months and meeting the prior year's net earnings threshold ($9,254 in 2025), with an unconditional withdrawal window within 60 days of registration.
EI Sickness Benefits Dual Benchmarks and Family Supplement	EI sickness benefits & Family Supplement	The 2022 exam benchmark sets EI sickness benefits at a maximum of 15 weeks (weekly maximum around $638, former 420-hour threshold), whereas current 2026 legislation provides up to 26 weeks at a 55% earnings replacement rate (weekly maximum $729, requiring 600 insurable hours and a weekly earnings reduction over 40%); families with net income up to $25,921 receiving the CCB for children under 18 receive an added Family Supplement.
CPP Disability Benefit Criteria and Waiting Period	CPP disability benefit (CPP-D) — Severe and prolonged	Applicants must satisfy age, contribution history, and the medical threshold of severe and prolonged disability (regularly incapable of pursuing any substantially gainful occupation, with an indefinite duration or likely fatal prognosis); benefits are taxable and typically begin in the fourth month following the month disability is determined.
RDSP Contribution, Grant Matching, and Clawback Rules	Registered Disability Savings Plan (RDSP)	The RDSP is available to individuals eligible for the Disability Tax Credit (DTC), featuring a $200,000 lifetime private contribution limit (no annual limit, contributions permitted until December 31 of the year the beneficiary turns 59), lifetime maximums of $70,000 for CDSG and $20,000 for CDSB (matching grants available until age 49), and an assistance holdback amount (AHA) repayment rule that claws back up to $3 in grants for every $1 withdrawn.
Selection Criteria for Income Approach Versus Expense Approach	Income approach vs. Expense approach	The income approach calculates the benefit required to maintain lifestyle as a fixed percentage of gross earnings (typically 60%), while the expense approach tallies essential outlays to establish a baseline survival budget; if the income approach premium exceeds client affordability, the agent should structure coverage using the expense approach supplemented with a future purchase option (FPO) rider.
Group LTD Taxation and Direct Offset Calculations	Taxability of benefits & Direct offset	Group LTD benefits are taxable if the employer pays any portion of the premium and tax-free if the employee pays 100% of the premium; under a direct offset clause, pre-tax CPP-D is subtracted dollar-for-dollar from the nominal LTD benefit, and after-tax CPP-D is added to the remaining LTD to determine net take-home income.
Roles of the Net Worth Statement and Cash Flow Statement	Net worth statement vs. Cash flow statement	The net worth statement (assets at fair market value minus liabilities) determines whether a client has sufficient liquid reserves to self-insure through an elimination period; the cash flow statement (tracking monthly net income minus expenditures) verifies whether discretionary cash flow exists to afford insurance premiums.
Four Coverage Adequacy Scenarios and the All-Source Maximum	Coverage adequacy & All-source maximum	Comparing net available benefits against calculated needs classifies coverage into adequate, excessive, overlapping above the all-source maximum (commonly 85% of pre-disability gross income, which triggers a reduction in group benefits), or deficient; when a gap exists, coverage must be sized to cover the largest gap across the disability timeline.

Self-test cues (Cornell left column)

1. Why do self-employed individuals and salaried employees have systematically different insurable income bases, verification documents, EI eligibility, and elimination periods despite completing the same profiling questionnaire?
2. What are the benefit durations and qualifying hour thresholds for EI sickness benefits under the exam benchmark versus current 2026 legislation, and why cannot EI benefits be treated as automatic extra income on top of group coverage?

3. Under employer–paid versus employee–paid premium arrangements, how do direct offsets of taxable CPP–D against group LTD benefits impact net take–home income and the resulting monthly coverage gap step by step?
4. What distinct questions do the income approach versus expense approach and the net worth statement versus cash flow statement answer, and how should an agent structure coverage when the client faces premium budget constraints?
5. Why must a caregiving cushion be built into the disability needs analysis for a dual–earner household, and what compliant actions correspond to the four coverage adequacy scenarios (adequate, excessive, overlapping above the 85% cap, and deficient)?

Summary: In three sentences, summarize the complete diagnostic progression: gathering objective evidence across the nine profiling blocks, distinguishing employee versus self–employed rules, clarifying the taxation and direct offsets of government and group benefits, and deploying the net worth and cash flow statements to structure a viable gap solution.

Chapter 19 · A&S Recommendation, Contract and Service: Statutory Conditions, Claims and Renewability

Accident & Sickness | P1 Must score | Recommendation, Contract & Service · 9 mock questions

Read with these questions: When a client exceeds their budget and seeks to reduce premiums, which of the four adjustment levers restores the insurer's unilateral right to revoke coverage?; If an insured is comatose in the hospital and reports a disability claim after more than 30 days, is the claim still payable under the exam benchmark and BC statutory rules?; If an insured switches to a higher–risk occupation without notifying the insurer, can the insurer deny the claim outright when an injury occurs?; When an individual accident and sickness policy has been delivered to the client but the initial premium has not yet cleared, is the contract binding on the insurer?

How it is tested

- Premium adjustment levers under budget constraints questions: Given a scenario where a client finds premiums unaffordable, test what coverage is sacrificed under each of the four levers (extending the elimination period, shortening the benefit period, reducing the benefit amount, or changing the renewability tier), and why switching to a cancellable policy carries the highest cost.
- Statutory condition time limits discrimination questions: In a claims scenario mixing the 30–day written notice, 90–day proof of claim, and exam–benchmark 6–month (BC current statute 1–year) late notice relief limit, test whether candidates can distinguish notice from proof deadlines and apply relief rules when timely reporting is objectively impossible.
- Renewability tiers comparison questions: Given non–cancellable, guaranteed renewable, cancellable, or conditionally renewable contracts, test whether an insurer can unilaterally terminate the policy during the service period, whether it can adjust premiums individually or en masse by rate class, and the statutory notice period for termination (15 days by registered mail or 5 days personal delivery).
- Cross–product line boundary questions: In scenarios involving delivery without initial premium payment, lapse and reinstatement, change of occupation to a higher–risk role, or irrevocable beneficiary designation, test whether candidates can avoid conflation with life insurance rules and correctly apply accident and sickness statutory conditions (such as pro–rata benefit adjustments and the binding nature of delivery upon the insurer).
- Claims payment schedule and group conversion practical questions: Test statutory deadlines for the initial loss–of–income payment (within 30 days) and ongoing payments (at least every 60 days) after receiving proof of claim, and the requirement to verify specific plan documents when converting group A&S to individual coverage upon employment termination rather than blindly applying group life conventions.

Traps (watch for the signal)

Confusing the Three Claim Time Limits Trap: The question stem mentions days elapsed following an accident or disability (e.g., day 45), hospitalization preventing management of affairs, or deadlines for submitting receipts or medical proof.

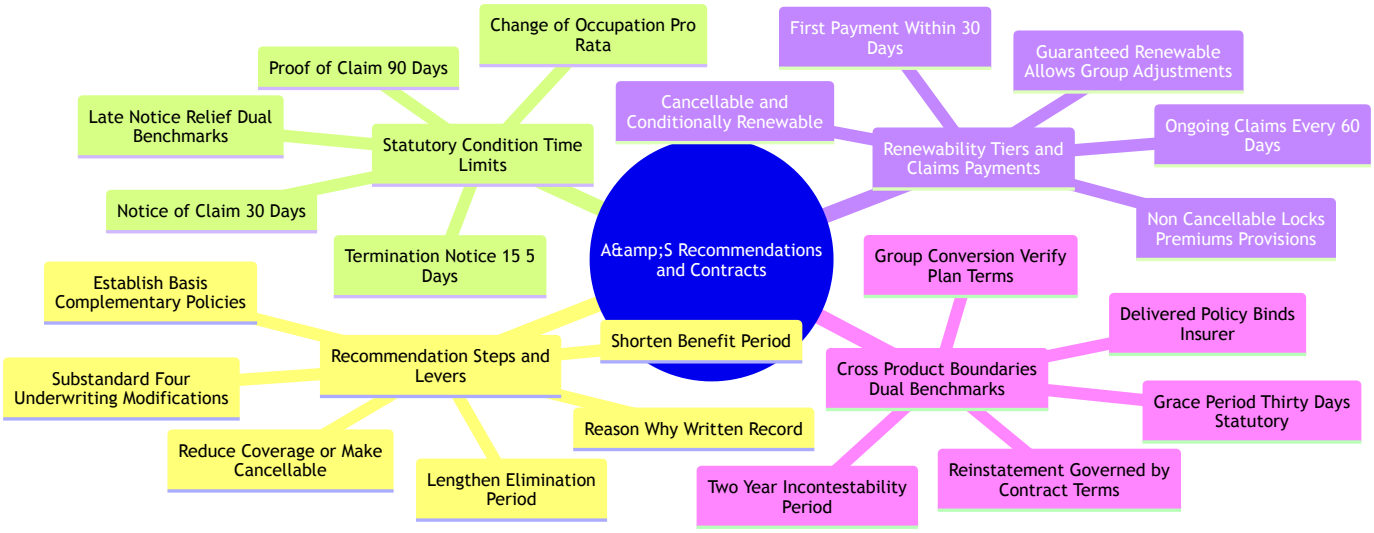
Equating Guaranteed Renewable with Non–Cancellable Trap: The question stem asks whether the insurer can adjust premiums or refuse renewal during the service period, or contrasts non–cancellable with guaranteed renewable provisions.

Assuming Claim Denial for High–Risk Change of Occupation Trap: The question stem describes an insured switching to a higher–risk occupation (change of occupation) after policy issuance and suffering a loss during work or everyday life.

Transposing Life Insurance Issue and Reinstatement Rules Trap: The question stem presents an A&S policy delivered without initial premium payment, a change in health prior to delivery, or asks for the reinstatement deadline following policy lapse.

Expecting Deferred First Claim Payment or Blindly Applying Group Conversion Days Trap: The question stem involves the claims payment schedule for long–term disability, or an employee applying to convert group A&S coverage to an individual policy upon termination.

Mind map


A&S Recommendations and Contracts
Statutory Condition Time Limits
Change of Occupation Pro Rata
Proof of Claim 90 Days
Late Notice Relief Dual Benchmarks
Notice of Claim 30 Days
Termination Notice 15 5 Days
Renewability Tiers and Claims Payments
First Payment Within 30 Days
Guaranteed Renewable Allows Group Adjustments
Cancellable and Conditionally Renewable
Ongoing Claims Every 60 Days
Non Cancellable Locks Premiums Provisions
Recommendation Steps and Levers
Establish Basis Complementary Policies
Substandard Four Underwriting Modifications
Reduce Coverage or Make Cancellable
Lengthen Elimination Period
Shorten Benefit Period
Reason Why Written Record
Cross Product Boundaries Dual Benchmarks
Group Conversion Verify Plan Terms
Delivered Policy Binds Insurer
Grace Period Thirty Days Statutory
Two Year Incontestability Period
Reinstatement Governed by Contract Terms

Chapter 19Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Notice of Claim and Proof of Claim Time Limits	notice of claim / proof of claim	Written notice of claim must be given to the insurer within 30 days from the date the claim arose (Condition 5(1)(a)), and written proof of claim must be submitted within 90 days from the date the claim arose (Condition 5(1)(b)); both periods run concurrently from the onset of the claim.
Late Notice Relief and Dual Benchmark Upper Limits	late notice relief	If giving notice or proof within the standard 30 or 90 days is not reasonably possible and is completed as soon as reasonably possible thereafter, the claim is not invalidated; the exam benchmark specifies a maximum late window of 6 months, whereas current BC statutory Condition 5 sets the absolute limit at no later than 1 year.
Insurer Unilateral Termination Notice and Renewability Tiers	termination of insurance / non-cancellable / guaranteed renewable	By statutory default, insurer termination of an individual policy requires at least 15 days notice by registered mail or 5 days notice personally delivered (Condition 4); non-cancellable contracts fully lock in both premiums and provisions, whereas guaranteed renewable contracts cannot be terminated but permit class-wide premium adjustments by rate classification.
Change of Occupation Clause and Pro-Rata Benefit Reduction	change of occupation clause	If an insured suffers a loss after engaging in an occupation classified as higher risk than that stated in the policy, the insurer does not deny the claim, but pays the reduced benefit that the premium paid would have purchased under the new occupational rate (s.101 Condition 3).
Four Premium Adjustment Levers and Trade-Off Costs	managing premiums	When client budget constraints arise, premiums can be managed by lengthening the elimination period, shortening the benefit period, reducing the benefit amount, or modifying policy renewability (such as switching to cancellable); switching to cancellable carries the highest sacrifice because it restores the insurer's unilateral right to terminate coverage.
Four Underwriting Modifications for Substandard Risks	exclusion / limitation / rating / deductible	When an applicant presents substandard medical or occupational risk, insurers frequently issue coverage using one or a combination of four modifications: exclusions, limitations, ratings (extra premiums), or deductibles, rather than outright declining the application.
Initial Claim Payment, Ongoing Payouts, and Non-Income Benefits	payment of claims	The insurer must furnish proof of claim forms within 15 days of receiving notice (Condition 6); loss-of-income benefits must have their initial payment made within 30 days after receiving proof of claim and ongoing payments made at least every 60 days during continuous disability (Condition 9), while non-income benefits must be paid within 60 days of proof (Condition 8).
Delivered Policy Enforceability and Statutory Grace Period	grace period	Once an accident and sickness policy is delivered, it is binding on the insurer even if the initial premium remains unpaid (with the insurer retaining the right to recover the premium, s.106(1)); renewal premiums following the initial premium receive a statutory grace period of at least 30 days (or longer if contractually specified, s.106).
A&S Policy Reinstatement and Incontestability Clock	reinstatement / incontestability period	Accident and sickness legislation does not establish a universal statutory reinstatement window like life insurance, leaving reinstatement conditions to the contract; however, disclosures upon reinstatement are subject to section 113, and the two-year incontestability period (s.112) runs afresh from the reinstatement date.
Irrevocable Beneficiary Designation and Group Conversion Windows	irrevocable beneficiary	An irrevocable beneficiary designation under an accident and sickness policy must be made by non-testamentary instrument during the insured's lifetime and delivered to the insurer's Canadian head office or chief agency to take effect (s.118); the group A&S conversion window appears as both 30 days and 31 days in exam materials, requiring advisors in practice to verify specific group plan documents.

Self-test cues (Cornell left column)

1. When a client finds individual disability insurance premiums unaffordable, which four contractual levers can reduce cost, and why should converting guaranteed renewable to cancellable coverage be the absolute last resort?

2. Under section 101 statutory conditions, what are the exact deadlines for notice of claim, proof of claim, and late notice relief, and what is the key distinction between the exam benchmark and current BC legislation regarding late relief limits?
3. What are the precise operational differences among non–cancellable, guaranteed renewable, and cancellable contracts regarding the insurer's unilateral rights to terminate coverage or increase premiums during the policy term?
4. If an insured switches to a higher–risk occupation after policy inception without notifying the insurer, how is a subsequent disability claim handled under statutory Condition 3?
5. How do legal rules governing accident and sickness policies fundamentally differ from life insurance regarding policy delivery without initial premium payment and reinstatement following policy lapse?

Summary: In three sentences, summarize: the trade–off logic among the reason–why documentation and four premium reduction levers, the critical statutory time limits under section 101 (30 days, 90 days, 6 months or 1 year, 15 or 5 days, and 30 or 60 days), and the essential legal boundaries separating accident and sickness insurance from life insurance regarding policy formation, reinstatement, and conversion windows.

Chapter 20 · Group Benefit Plans: Eligibility, Rating, Co-ordination of Benefits, and ASO

Accident & Sickness | P3 Skim | Group Plans · 1 mock questions

Read with these questions: If a company has stable cash flow but only 40 employees, wants to reduce costs, and desires a custom formulary, which funding method should it choose?; After EI sickness benefits were extended to 26 weeks, did the minimum benefit duration requirement change for employers applying for an STD premium reduction?; Given a group credibility of 30%, an experience rate of $45, and a manual rate of $60, what is the blended rate?; When spouses have birthdays in March and July, how do their two plans co-ordinate payment for their child's $600 dental bill?

How it is tested

- Matching employer profile to funding method: Given an employer's group size, cash flow condition, stability of claims history, and demand for plan design autonomy, test your ability to determine whether to select non-refund accounting, refund accounting, or Administrative Services Only (ASO).
- Blended rating and credibility determination: Given group size (e.g., the 25-employee threshold), annual employee turnover rate (5–10% per year is considered low), and years of claims history, test your ability to assess credibility levels or calculate a blended rate by weighting experience rating and manual rating by credibility.
- Dual-income family coordination of benefits (COB) calculation: Given the reimbursement percentages under both spouses' employer plans and the parents' birth months, test your ability to identify the primary payer using the birthday rule, and calculate the secondary payer's top-up amount and the out-of-pocket family cost using the lesser-of rule.
- Taxation of group disability benefits and cumulative contribution deductions: Given a long-term disability (LTD) plan where the employer and employee share premium costs (e.g., 50% each), test your ability to deduct cumulative unapplied employee contributions (rather than applying the annual premium split percentage) from the current year's taxable disability benefits.
- EI sickness benefits and ESDC premium reduction eligibility: Given an employer's short-term disability (STD) benefit duration (15 weeks) and income replacement ratio (55%), test your ability to distinguish the dual benchmarks for EI sickness benefit duration (15 weeks for exam purposes vs. 26 weeks under current law) and the eligibility thresholds for the ESDC EI Premium Reduction Program.

Traps (watch for the signal)

Treating premium sharing percentage as taxable benefit percentage: The question stem simultaneously provides an employer–employee premium split percentage (e.g., 50%) and the employee's cumulative unapplied contribution amount (e.g., $3,600).

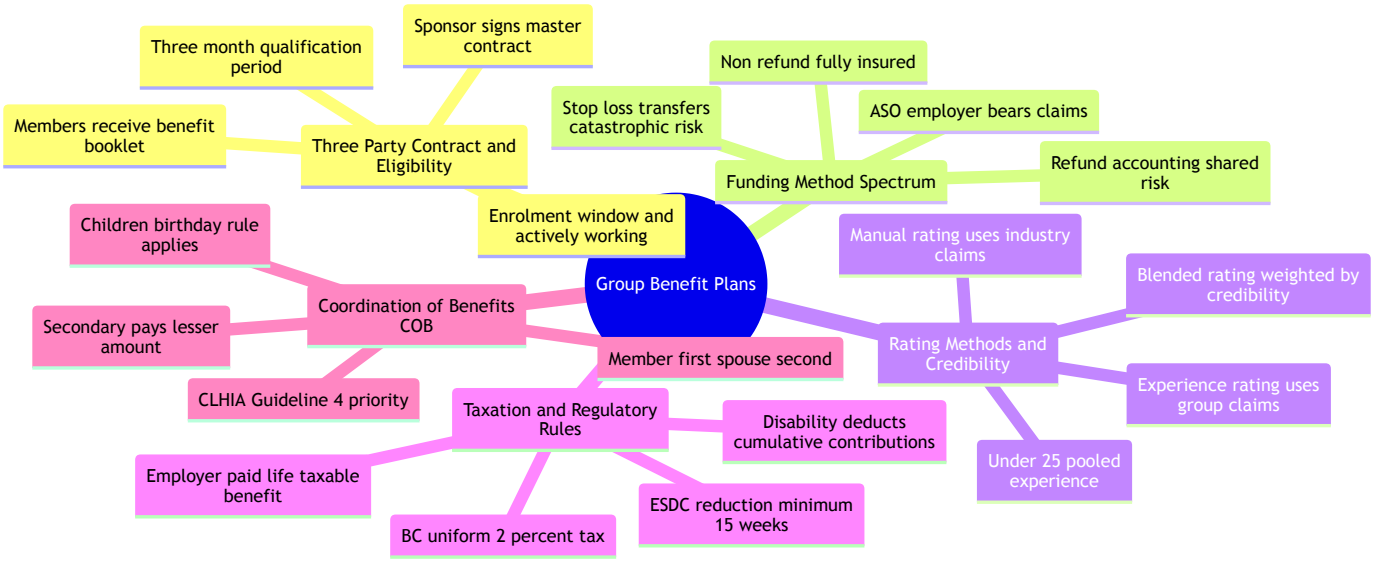
Reversing credibility weighting in blended rating: The question stem gives a credibility percentage (e.g., 30%) alongside both experience and manual rates, or asks for the credibility rating of a newly formed group or one with fewer than 25 employees.

Misjudging birthday rule criteria and omitting the lesser-of comparison for secondary payer: The question stem provides both spouses' birth months, an eligible medical or dental bill for a dependent child, and differing reimbursement percentages under two group plans (e.g., 80% and 100%).

Confusing extended EI duration with the ESDC reduction threshold: The question stem asks for the minimum benefit duration requirement (at least 15 weeks) for an employer STD plan to qualify for the EI Premium Reduction Program, or asks about EI sickness benefit duration.

Misunderstanding ASO as unmanaged self-insurance or ignoring risk volatility: The question stem describes an employer seeking to reduce premium costs or customize its benefit formulary, while noting its headcount (e.g., fewer than 25 or 40 employees), cash flow condition, and risk tolerance.

Mind map


Group Benefit Plans
Three Party Contract and Eligibility
Three month qualification period
Sponsor signs master contract
Members receive benefit booklet
Enrolment window and actively working
Funding Method Spectrum
Non refund fully insured
ASO employer bears claims
Stop loss transfers catastrophic risk
Refund accounting shared risk
Rating Methods and Credibility
Manual rating uses industry claims
Blended rating weighted by credibility
Experience rating uses group claims
Under 25 pooled experience
Coordination of Benefits COB
Children birthday rule applies
Secondary pays lesser amount
CLHIA Guideline 4 priority
Member first spouse second
Taxation and Regulatory Rules
Disability deducts cumulative contributions
Employer paid life taxable benefit
BC uniform 2 percent tax
ESDC reduction minimum 15 weeks

Chapter 20Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Three-party relationship and statutory rights under group contracts	plan sponsor / master contract / benefit booklet	The master contract is executed between the plan sponsor (the employer) and the insurer; plan members receive only a benefit booklet summary and are not contracting parties, but under BC Insurance Act s. 96 they retain statutory rights to obtain policy copies, while s. 99 governs certificates.
Law of large numbers and the 25-employee threshold	law of large numbers / pooled experience / turnover rate	Groups with fewer than 25 employees lack sufficient claims data to support independent actuarial pricing and must be pooled into an experience pool of similar small groups; an annual employee turnover rate of 5–10% is considered low and favourable for pricing.
Risk-transfer spectrum across three funding methods	non-refund accounting / refund accounting / Administrative Services Only (ASO)	Across the spectrum from non-refund accounting (fully insured: insurer bears all claims risk and keeps surpluses), to refund accounting (shared claims volatility: partial premium refund when claims are lower than expected), to Administrative Services Only (ASO: employer bears claims risk and keeps all surpluses, optionally paired with stop-loss insurance), the employer assumes progressively higher volatility.
Federal tax treatment of group premiums and benefit payments	taxable benefit / cumulative employee contributions	Employer-paid premiums for group term life and scheduled AD&D constitute a taxable benefit to employees; employer-contributed STD and LTD plans generate no taxable benefit when premiums are paid, but periodic benefits received are taxable under ITA s. 6(1)(f) after deducting the employee's cumulative unapplied premium contributions.
Dual benchmarks for EI sickness benefits and ESDC premium reduction	ESDC EI Premium Reduction Program	The exam benchmark for EI sickness benefits is 15 weeks at 55% capped at $638 per week (under current law extended to 26 weeks capped at $729 per week), but the minimum benefit duration requirement for an employer STD plan to register for an ESDC premium reduction remains at least 15 weeks, while the weekly dollar cap adjusts annually to match the prevailing EI maximum.
Three coverage eligibility hurdles for new employees	qualification period / enrolment window / actively-at-work requirement	New employees typically must satisfy a qualification period (commonly 3 months), complete enrolment within a 30–60 day enrolment window, and meet the contract's actively-at-work requirement (or deemed actively-at-work status).
Three group rating methods and the blended rating formula	manual rating / experience rating / blended rating / credibility	Blended rate = (credibility * experience rate) + ((1 – credibility) * manual rate); larger group size, lower employee turnover, and longer claims history increase credibility, while new groups with no claims history have zero credibility.
Co-ordination of benefits (COB) and the birthday rule for dependent children	co-ordination of benefits (COB) / birthday rule / CLHIA Guideline G4	Under CLHIA Guideline G4, dependent child claims are paid first by the plan of the parent whose birthday falls earlier in the calendar year (stepparent plans rank behind natural parents); the secondary payer pays the lesser of the benefit it would have paid as primary and the unpaid balance left by the primary plan.
Provincial group premium taxes and the BC standard	group premium tax	Provinces levy a general premium tax of 2–3% on insurance premiums (Ontario, Quebec, and Manitoba also levy separate retail sales taxes on group benefits), whereas BC levies a uniform 2% insurer tax under the Insurance Premium Tax Act without distinguishing between group and individual policies.

Self-test cues (Cornell left column)

1. Why do group plan employees not receive the original master contract, and what status does this give employees when an employer changes insurers?
2. Under fully insured (non-refund), refund accounting, and ASO arrangements, who bears the claims risk and who keeps any claims surplus?
3. How do the 25-employee group threshold, turnover rate, and claims history length affect credibility and blended rating calculations?
4. In an LTD plan where employer and employee each pay 50% of the premium, why are disability benefits not taxed at 50%?
5. When a dual-income family claims dental expenses for a child, how is the primary payer determined and how much does the secondary payer pay?

Summary: In one sentence, summarize the four core rules of group plans: how much risk the employer bears across funding methods, how actuaries calculate premiums using credibility, how CRA taxes benefits based on cumulative employee contributions, and who pays first under the birthday rule when multiple plans apply.

Chapter 21 · Investment and Savings Basics: Compounding, Registered Accounts, and the FHSA Missing from the Exam Manual

Segregated Funds & Annuities | P2 Hold steady | Investment Basics · 3 mock questions

Read with these questions: When the nominal return is positive but inflation is higher, what is the client's real return?; After withdrawing from a fully maximized TFSA, what is the earliest date the client can re-contribute that withdrawn amount without penalty?; Which regulatory and protection bodies oversee stock brokers, mutual fund dealers, and segregated fund sales, respectively?; When a client's net worth statement shows $600,000 in assets held entirely in GICs, how should the agent evaluate their risk profile?

How it is tested

- Time value of money and inflation calculation questions: Given principal, nominal return, inflation rate, and time horizon, testing compounding future value calculations, estimating doubling time using the Rule of 72, or distinguishing between positive and negative real returns versus nominal returns.
- Registered account rules and tax consequence questions: Setting client contribution, withdrawal, or over-contribution scenarios to test RRSP, TFSA, RESP, RDSP, RRIF, and FHSA contribution limits, tax deductibility, withdrawal taxation rules, the 1% per month over-contribution penalty tax, and TFSA room restoration the following year.
- Investor protection and regulatory jurisdiction matching questions: Given specific investment vehicles held by a client (GICs, stocks, mutual funds, segregated funds, annuities), testing whether CDIC, CIPF, or Assuris provides protection in the event of institutional insolvency, and verifying that segregated funds fall under provincial insurance regulation rather than securities self-regulatory organizations.
- Dual benchmark and regulatory evolution questions: Addressing differences between the exam reference manual (written in 2022) and current rules (such as IIROC and MFDA merging into CIRO, CIPF and IPC merging, and the introduction of the FHSA and CPP2), distinguishing between exam benchmark answers and current practical rules based on how the question stem is phrased.
- KYC assessment and four-dimensional product suitability scenario questions: Combining a client's investment time horizon, risk tolerance, and risk capacity to evaluate whether an investment vehicle or account structure matches across four dimensions: risk, return, liquidity, and taxation.

Traps (watch for the signal)

TFSA same-year re-contribution over-contribution trap: The question stem features a client who has already maximized their TFSA contribution room for the year, withdraws funds, and plans to deposit funds back into the TFSA before the end of the same year.

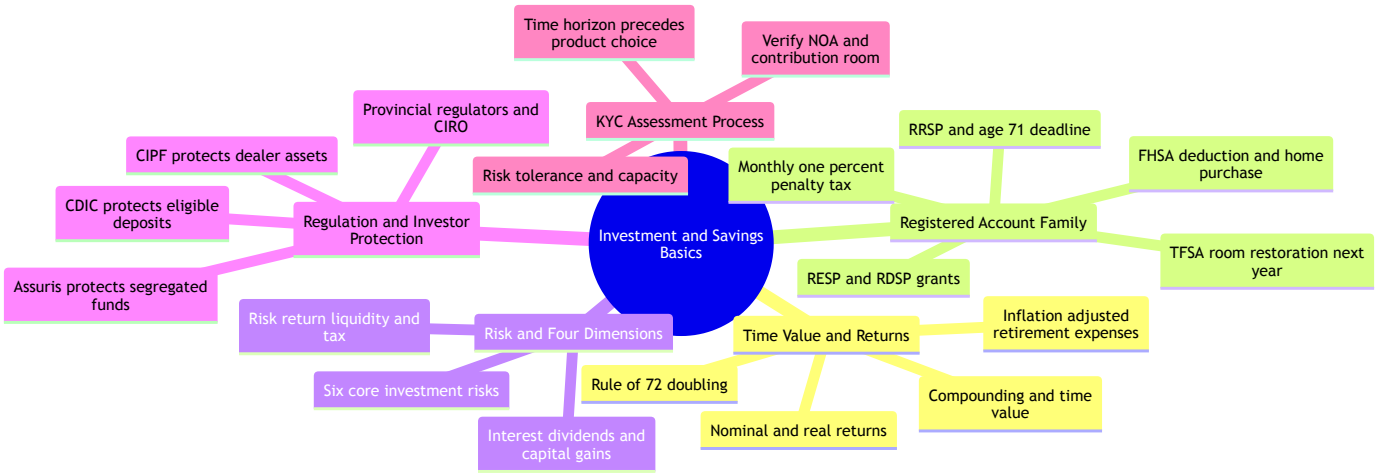
RRSP contribution base year and dollar limit omission trap: The question stem provides both previous-year and current-year income, or gives a very high income and asks for new RRSP contribution room generated for the current year.

Segregated fund regulation and protection mismatch trap: The question stem asks which regulator oversees segregated fund sales, which entity protects against insolvency, or asks how much a protection fund pays during a 20% market decline.

Nominal return masking negative real return trap: The question stem provides both a product's nominal return and the annual inflation rate, where inflation is close to or higher than the return, asking how the client's actual purchasing power changes.

High net worth equating to high risk capacity trap: The question stem emphasizes that the client's net worth statement shows substantial assets held entirely in GICs or savings accounts, asking what conclusion the agent can draw during the assessment phase.

Mind map


Investment and Savings Basics
KYC Assessment Process
Time horizon precedes product choice
Verify NOA and contribution room
Risk tolerance and capacity
Regulation and Investor Protection
Provincial regulators and CIRO
CIPF protects dealer assets
CDIC protects eligible deposits
Assuris protects segregated funds
Registered Account Family
RRSP and age 71 deadline
FHSA deduction and home purchase
TFSA room restoration next year
RESP and RDSP grants
Monthly one percent penalty tax
Time Value and Returns
Inflation adjusted retirement expenses
Compounding and time value
Nominal and real returns
Rule of 72 doubling
Risk and Four Dimensions
Risk return liquidity and tax
Six core investment risks
Interest dividends and capital gains

Chapter 21Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Difference between compound and simple interest and the Rule of 72	compounding / Rule of 72	Compounding reinvests earned interest back into principal to earn additional interest (FV = PV * (1 + r)^n), accelerating exponentially over longer horizons; dividing 72 by the annual return percentage estimates the years required for principal to double (most accurate between 6% and 10%).
Converting between nominal return and real return	nominal return / real return	Exact real return = (1 + nominal return) / (1 + inflation rate) – 1 (for small values, nominal return minus inflation provides an approximation); when inflation exceeds nominal return, real return is negative and purchasing power declines.
RRSP contribution room and age 71 maturity options	Registered Retirement Savings Plan (RRSP)	New RRSP contribution room is the lesser of 18% of the previous year's earned income and the annual dollar limit ($33,810 for 2026); an individual RRSP must mature by December 31 of the year the plan holder turns 71 via lump-sum withdrawal, transfer to a RRIF, or purchasing an eligible annuity.
TFSA tax-free withdrawals and next-year room restoration	Tax-Free Savings Account (TFSA)	TFSA contributions are after-tax, withdrawals are tax-free and do not affect income-tested benefits like OAS or GIS ($7,000 annual limit for 2026); withdrawn amounts are not restored until January 1 of the following calendar year, and re-contributing without available room triggers a 1% per month penalty tax on the excess amount.
FHSA dual tax advantages and contribution limits	First Home Savings Account (FHSA)	Introduced in 2023, the FHSA combines tax-deductible contributions with tax-free withdrawals for a qualifying first home purchase, with an $8,000 annual participation limit, $40,000 lifetime limit, and up to $8,000 in unused room carryforward per year (unmentioned in the exam manual due to its 2022 publication date).
RESP and RDSP lifetime limits and grant taxation	Registered Education Savings Plan (RESP) / Registered Disability Savings Plan (RDSP)	Contributions to RESPs and RDSPs are non-deductible with no annual contribution limits (lifetime limits are $50,000 and $200,000 per beneficiary, respectively); on withdrawal, original contributions return tax-free, while government grants (CESG/CDSG, etc.) and accumulated earnings are taxed as income in the hands of the beneficiary.
Protection boundaries of three investor protection organizations	CDIC / CIPF / Assuris	CDIC protects eligible deposits at member institutions ($100,000 principal and interest per category per institution), CIPF protects client property held by investment and mutual fund dealers, and Assuris protects life insurance policies (including segregated funds and annuities); all three protect solely against member insolvency, never against market downturn losses.
Dual regulatory benchmarks and segregated fund jurisdiction	CIRO (formerly IIROC and MFDA)	The exam manual refers to securities and mutual fund self-regulatory bodies as IIROC and the MFDA (with protection funds CIPF and IPC), which merged in current practice into CIRO and a single CIPF; however, segregated funds are insurance contracts regulated exclusively by provincial insurance regulators.
Taxation of three types of non-registered investment income	capital gains inclusion rate	In non-registered accounts, interest is 100% taxable at the marginal rate, eligible Canadian dividends receive a gross-up and dividend tax credit, and capital gains are included in taxable income at a 50% inclusion rate.
Three KYC risk dimensions and client profiling before product selection	risk tolerance / risk capacity / risk perception	During the assessment phase, agents must document subjective risk tolerance, objective risk capacity, and risk perception separately, verify NOA contribution room and time horizon, and never infer high risk capacity solely from a high net worth on a balance sheet.

Self-test cues (Cornell left column)

1. Why are registered accounts considered merely shopping bags, and what are the legal consequences of an over-contribution?
2. How do you convert between nominal and real returns, and how is the Rule of 72 applied along with its limitations?
3. What are the core differences among RRSPs, TFSAs, FHSAs, RESPs, and RDSPs regarding contribution deductibility, withdrawal taxation, and room restoration?
4. What do CDIC, CIPF, and Assuris protect, and what dual benchmark differences exist between IIROC/MFDA and CIRO, as well as segregated fund regulation?

5. Why must risk tolerance and risk capacity be distinguished during KYC assessment, and why does high net worth not imply high risk capacity?

Summary: In three sentences, summarize the core rules of this chapter: first, explain how the time value of money (compounding and real return) determines the investment starting point; second, contrast the tax-shelter rules across the five major registered accounts; third, delineate the protection boundaries of CDIC, CIPF, and Assuris alongside the regulatory framework.

Chapter 22 · Segregated Funds: Guarantees, Protection, and How They Really Differ from Mutual Funds

Segregated Funds & Annuities | P1 Must score | Segregated Funds · 5 mock questions

Read with these questions: How do segregated funds bypass probate and protect against creditors, and how do the beneficiary requirements differ between the two?; How should questions on Assuris insolvency protection or the DSC ban be answered under the exam benchmark versus current rules?; How are the maturity date and guarantee base adjusted when a client makes subsequent deposits, takes partial withdrawals, or resets guarantees?; Can an insurer top-up trigger if a contract is surrendered before maturity, or if the annuitant dies before the maturity date?

How it is tested

- Guarantee trigger and settlement calculation questions: Given initial deposit, guarantee percentages (such as 75%/75% or 75%/100%), and market values at different points in time, test the actual payout amount and insurer top-up upon maturity, death, or early partial or full surrender.
- Beneficiary designation and dual-protection analysis questions: Using scenarios where a client wishes to bypass probate or protect against creditor claims, test the distinction between direct payment conditions for a named non-estate beneficiary and the family member class under BC Insurance Act s. 65(2).
- Contract transaction consequence assessment questions (subsequent deposits, resets, withdrawals, and switches): Test deposit date-based 10-year maturity calculations, resets locking in higher guarantee bases and extending the maturity date, proportional permanent reductions of guarantee bases upon partial withdrawals, and capital gains or losses triggered by fund switches.
- Multidimensional segregated fund versus mutual fund comparison questions: Focus on the legal nature of an IVIC insurance contract, the regulatory boundary between provincial insurance regulators (Insurance Council of BC and BCFSA) and securities regulation (CIRO), MER inclusive of insurance guarantee costs, and age limits (non-registered up to age 90, RRSP to age 71).
- Exam benchmark (2022) versus current rules (2026) dual-standard questions: Test Assuris insolvency protection limits (exam benchmark $60,000 or 85% versus current $100,000 or 90%), the legal basis for the deferred sales charge (DSC) ban (BC Financial Institutions Act), and the court probate application fee ($208 versus $200).

Traps (watch for the signal)

Confusing maturity guarantee with death benefit guarantee: The question stem displays two slash-separated figures (e.g., 75/100), the annuitant dies before the 10-year term matures, or the scenario asks which guarantee protects an investor who fears losing principal during their lifetime.

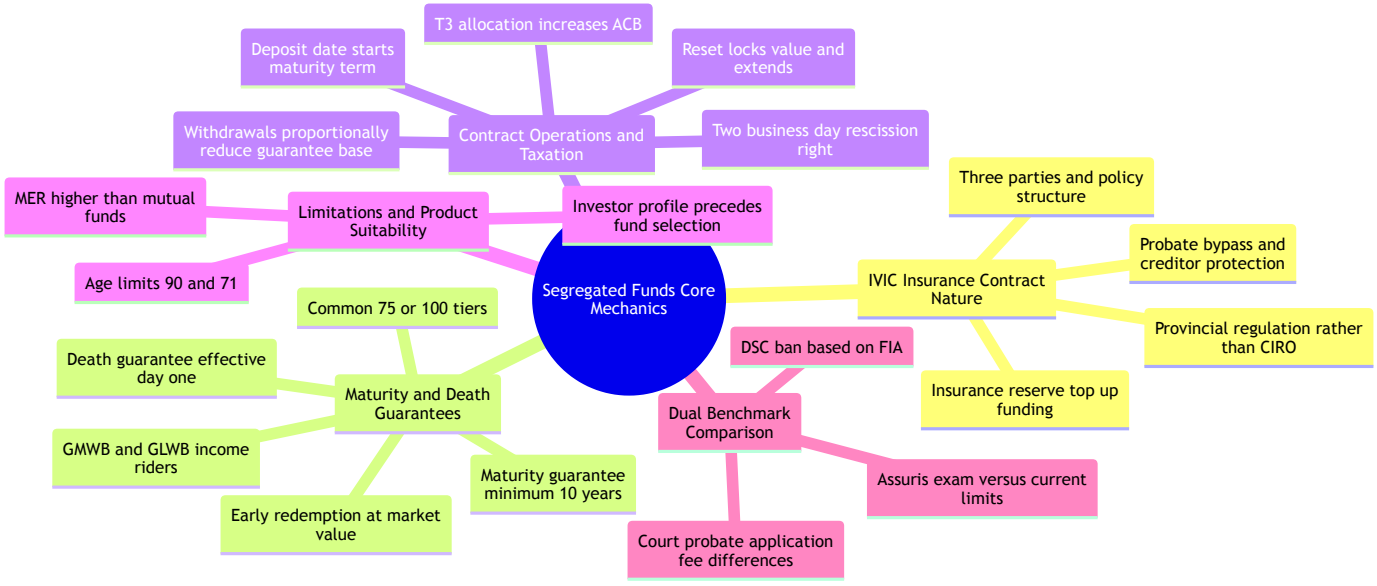
Erroneously applying guarantee top-ups to early redemptions: The question stem mentions an urgent need for funds requiring full surrender in year 6 or 7, or early redemption before maturity while market value is below 75% of the original deposit.

Consolidating maturity dates for subsequent deposits: The question stem describes a client making subsequent deposits in successive years under a deposit date-based contract, asking for the maturity date or cumulative maturity guarantee of the second or third deposit.

Conflating probate bypass with creditor protection requirements: The question stem names a friend, sibling, or charity as beneficiary and asks whether the contract bypasses probate or protects against creditors, or asks if a spouse must be named irrevocably to resist creditors.

Misaligning dual-benchmark figures with regulatory bodies: The question stem involves Assuris protection calculations upon insurer insolvency, the regulatory status and legislative authority for the DSC ban, or comparisons between segregated fund and mutual fund regulators.

Mind map


Segregated Funds Core Mechanics
Contract Operations and Taxation
T3 allocation increases ACB
Deposit date starts maturity term
Reset locks value and extends
Withdrawals proportionally reduce guarantee base
Two business day rescission right
Investor profile precedes fund selection
Limitations and Product Suitability
MER higher than mutual funds
Age limits 90 and 71
Maturity and Death Guarantees
Common 75 or 100 tiers
Death guarantee effective day one
GMWB and GLWB income riders
Early redemption at market value
Maturity guarantee minimum 10 years
IVIC Insurance Contract Nature
Three parties and policy structure
Probate bypass and creditor protection
Provincial regulation rather than CIRO
Insurance reserve top up funding
Dual Benchmark Comparison
DSC ban based on FIA
Assuris exam versus current limits
Court probate application fee differences

Chapter 22Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Legal nature of an Individual Variable Insurance Contract (IVIC) and three-party roles	Individual Variable Insurance Contract (IVIC)	A segregated fund is legally an insurance contract rather than mutual fund units, structured around a policy owner who funds the contract and makes investment decisions, an annuitant whose survival or death anchors the maturity and death guarantees, and a beneficiary who receives death benefits; in registered accounts, the owner and annuitant must be the same person.
Distinction of beneficiary designations for probate bypass and creditor protection	probate bypass and creditor protection	Naming a valid non-estate beneficiary bypasses probate (BC probate fees are 0 on estates up to $25,000, $6 per $1,000 on $25,000 to $50,000, and $14 per $1,000 over $50,000); in contrast, lifetime statutory protection against creditor seizure under BC Insurance Act s. 65(2) requires designating the annuitant's spouse, child, grandchild, or parent (without needing to be irrevocable).
Regulatory jurisdiction and licensing boundaries	regulatory jurisdiction and licensing	Segregated funds are insurance products whose sales representatives must hold a life insurance licence and are governed by provincial insurance regulators (in BC, the Insurance Council of BC and BCFSA), entirely outside the jurisdiction of CIRO, which regulates mutual funds and investment dealers.
Maturity guarantee, death benefit guarantee triggers, and insurer top-up	maturity guarantee, death benefit guarantee, and top-up	Maturity guarantees generally require a minimum 10-year term (commonly 75% or 100%) and settle automatically on the maturity date without a claim; death benefit guarantees take effect on day one of the contract; if market value is below the guaranteed amount when triggered, the shortfall is topped up from the insurer's reserves, but early redemptions settle strictly at current market value.
Deferred sales charge (DSC) ban and market conduct enforcement authority	deferred sales charge (DSC) ban	The exam benchmark (2022) states that segregated fund DSCs are expected to be banned; under current BC rules effective June 1, 2023, issuing new segregated fund contracts with DSCs is prohibited under the Financial Institutions Act s. 244(2)(e)(ii), while pre-existing contracts may run off according to their original redemption schedules.
Assuris insolvency protection limits under dual benchmarks	Assuris protection limits	If a life insurer becomes insolvent, segregated fund guaranteed benefits are protected under the exam benchmark (2022) up to $60,000 or 85% of the guaranteed amount (whichever is higher, capped at the original guarantee); under current standards effective May 29, 2023, the limit was increased to $100,000 or 90% (whichever is higher, capped at the original guarantee).
Tax treatment of allocations, adjusted cost base (ACB), and fund switches	allocation, adjusted cost base (ACB), and switch	Non-registered segregated funds allocate internally realized interest, dividends, and capital gains annually to policyholders (reported on a T3 slip), which increases the adjusted cost base (ACB) to avoid double taxation; a redemption or internal fund switch is treated as a taxable disposition, triggering a capital gain or loss based on the difference between proceeds and ACB (50% included in taxable income).
Right of rescission and five client-confirmed transactions	right of rescission	An information folder and Fund Facts must be delivered before entering into a contract; after the purchase confirmation is sent, the client generally has two business days to exercise the right of rescission, refunding the lesser of the amount invested or the current unit value; investor confirmation must be obtained for five transaction types: purchases, switches, resets, withdrawals, and terminations.
Guarantee calculations for resets, partial withdrawals, and subsequent deposits	reset, partial withdrawal, and deposit date-based maturity	In rising markets, a reset locks in the guarantee base at the higher current market value, but a maturity guarantee reset typically resets the 10-year maturity clock from the reset date; partial withdrawals permanently reduce the guarantee base on a proportional basis; under deposit date-based contracts, each subsequent deposit runs its own independent 10-year maturity period.

Self-test cues (Cornell left column)

1. Why can an Individual Variable Insurance Contract (IVIC) offer maturity guarantees, death benefit guarantees, probate bypass, and creditor protection, whereas mutual funds cannot?
2. What is the fundamental difference in beneficiary qualification between bypassing probate and achieving statutory creditor protection under BC Insurance Act s. 65(2)?

3. How are payouts calculated when the market value is below the guaranteed amount if a client surrenders fully in year 7, the annuitant dies in year 6, or the contract matures at year 10?
4. How do a contract's guarantee base and 10-year maturity date change when a client executes a reset, takes a partial withdrawal, or makes subsequent deposits?
5. What are the exam benchmark (2022) and current BC rules regarding Assuris protection limits, the DSC sales charge status, and the court probate application fee?

Summary: In three sentences, summarize the core legal advantages of segregated funds as Individual Variable Insurance Contracts (IVICs), the trigger and base adjustment rules for maturity and death benefit guarantees, and the differences between the 2022 exam benchmark and 2026 current figures that must be distinguished on the exam.

Chapter 23 · Annuities: Turning a Lump Sum into Lifetime Income, Annuity Classifications, and Prescribed Taxation

Segregated Funds & Annuities | P1 Must score | Annuities · 3 mock questions

Read with these questions: Can an annuity funded through installment deposits ever be an immediate annuity?; Can a non-registered deferred annuity switch to prescribed taxation once it enters the payout phase?; Under a joint and last survivor annuity with a guaranteed period, can the beneficiary immediately collect remaining payments upon the first spouse's death?; If a client has no estate needs and wants maximum monthly income, does adding a 20-year guaranteed period provide extra security or defeat the purpose?

How it is tested

- Client anxiety matching questions: Given a client's retirement concerns (such as fearing outliving their money, prioritizing capital liquidity, or wishing to preserve estate flexibility), test whether candidates can identify the corresponding risk mechanisms across life annuities, RRIFs, and segregated funds with a guaranteed lifetime withdrawal benefit (GLWB).
- Guaranteed period and joint-and-last-survivor rule discrimination questions: Setting up scenarios where a couple with no need to leave a cash estate is given a guaranteed period, or where a beneficiary claims payments immediately after the first annuitant's death under a joint-and-last-survivor annuity, test the discounting effect of a guaranteed period on monthly payments and the sequential trigger order under joint lives.
- Immediate versus deferred classification trap questions: Embedding deposit methods such as periodic installments or lump-sum deposits in the question stem, test whether candidates understand that the sole criterion distinguishing an immediate annuity from a deferred annuity is when payments commence, not how deposits are funded.
- Non-registered annuity taxation and dual-benchmark questions: Comparing the annual taxable progression of prescribed annuities versus accrual annuities and reassessing eligibility in the payout commencement year, or testing differences between exam benchmarks and current rules regarding Assuris payout annuity coverage limits and ALDA/VPLA commencement age limits.
- Insured annuity operational sequence questions: Describing a client who intends to use annuity cash flow to pay permanent life insurance premiums to lock in a tax-free death benefit, test the mandatory operational sequence requiring life insurance underwriting approval and issuance before purchasing a single life annuity.

Traps (watch for the signal)

Equating Deferred Annuities with Periodic Deposits Trap: The question stem emphasizes that a client deposits funds in multiple installments or as a single lump sum, asking candidates to classify the contract as an immediate or deferred annuity.

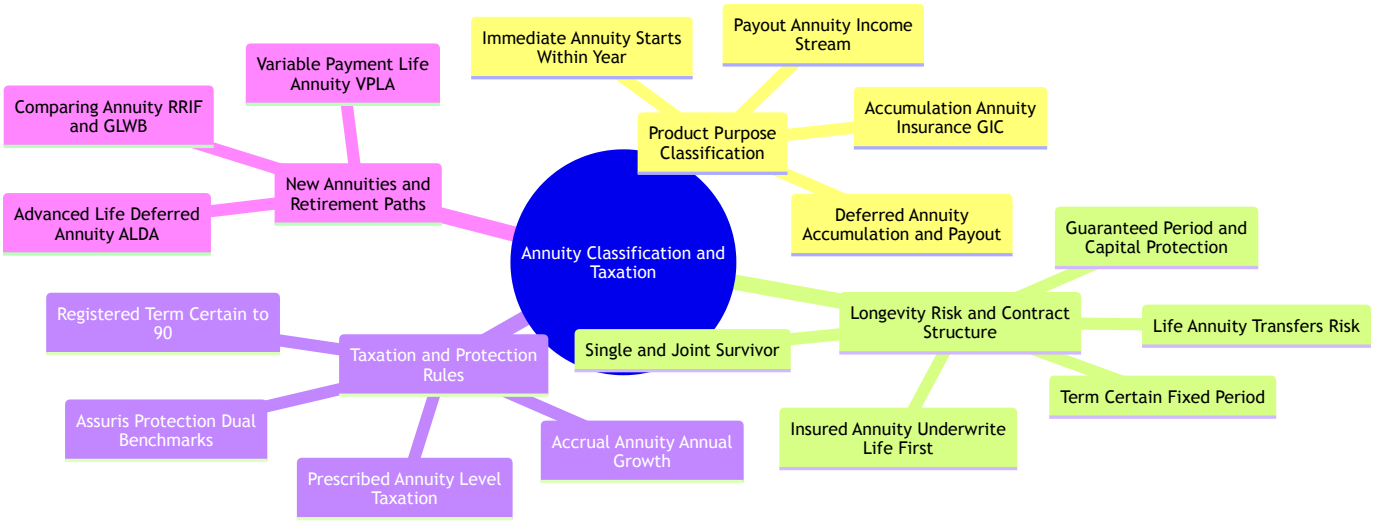
Assuming Adding a Guaranteed Period Benefits the Annuitant Trap: The question stem mentions both 'no need to leave an estate (independent adult children)' and 'maximizing monthly income during lifetime,' yet answer choices include a 10-year or 20-year guaranteed period.

Paying Beneficiaries Immediately Upon the First Annuitant's Death Trap: The scenario involves a joint-and-last-survivor annuity with a guaranteed period, describing that the first annuitant has just passed away and children as designated beneficiaries come forward to claim benefits.

Purchasing the Annuity Before Underwriting the Life Insurance in an Insured Annuity Trap: The question asks for the initial step in establishing an insured annuity strategy, or describes a client who bought an annuity first before undergoing medical exams for permanent life insurance.

Conflating Old and Current Benchmarks for Assuris and ALDA Trap: The question stem features an insolvent insurer owing a promised monthly payout of $5,000, or inquires about the maximum deferral age and transfer limits for an Advanced Life Deferred Annuity (ALDA).

Mind map


Annuity Classification and Taxation
Product Purpose Classification
Immediate Annuity Starts Within Year
Payout Annuity Income Stream
Accumulation Annuity Insurance GIC
Deferred Annuity Accumulation and Payout
New Annuities and Retirement Paths
Variable Payment Life Annuity VPLA
Comparing Annuity RRIF and GLWB
Advanced Life Deferred Annuity ALDA
Longevity Risk and Contract Structure
Guaranteed Period and Capital Protection
Life Annuity Transfers Risk
Term Certain Fixed Period
Insured Annuity Underwrite Life First
Single and Joint Survivor
Taxation and Protection Rules
Registered Term Certain to 90
Assuris Protection Dual Benchmarks
Prescribed Annuity Level Taxation
Accrual Annuity Annual Growth

Chapter 23Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Essential Distinction Between Payout and Accumulation Annuities	payout annuity vs. accumulation annuity	A payout annuity is designed to convert principal and interest into a scheduled income stream, whereas an accumulation annuity (insurance GIC) generates no income stream and merely holds deposits to earn interest, allowing conversion to a payout annuity or penalty-free full surrender at maturity.
Classification Standard for Immediate and Deferred Annuities	immediate annuity vs. deferred annuity	The sole distinguishing criterion is when income payments begin: an immediate annuity must be purchased with a single lump sum and begin payments within the first payment interval (within one year), whereas a deferred annuity begins payments only after the accumulation phase ends; there is no such thing as an immediate annuity funded through periodic installment deposits.
Longevity Risk Allocation and Guaranteed Period Discounting	life annuity, term-certain annuity & guaranteed period	A life annuity transfers longevity risk to the insurer's risk pool, whereas a term-certain annuity does not transfer longevity risk; adding a guaranteed period (such as 5, 10, or 20 years), a capital protection guarantee, or a return-of-premium guarantee reduces the periodic payment amount because the insurer assumes additional death benefit liabilities.
Operational Structure and Purchase Sequence of an Insured Annuity	insured annuity	An insured annuity uses payments from a single life annuity to pay premiums on a permanent life insurance policy (such as T-100) while providing disposable living income; upon death, the life insurance pays a tax-free benefit to beneficiaries. Operationally, the life insurance must be medically underwritten and issued before the annuity is purchased.
Assuris Protection Limits for Annuity Holders	Assuris protection limits	Monthly income protection for payout annuities under the 2022 exam benchmark is the higher of $2,000 per month or 85% of promised payments (under the 2026 current rule, the higher of $5,000 per month or 90%); accumulation annuities are fully protected up to $100,000 under the exam benchmark (under the 2026 current rule, the higher of $100,000 or 90%).
Prescribed and Accrual Taxation for Non-Registered Annuities	prescribed annuity vs. accrual annuity	A non-registered prescribed annuity (meeting ITR section 304 conditions) maintains a level split between non-taxable principal return and taxable interest throughout the payout period, whereas an accrual annuity reports accrued income annually during the accumulation phase and is reassessed for prescribed eligibility in the year payouts commence.
Lock-In Effect of Prevailing Interest Rates at Issue	prevailing interest rates at issue	Payment rates for fixed annuities depend on long-term bond yields and actuarial assumptions on the date of issuance and are locked into the contract; for the same principal, monthly income issued during a rate-hike cycle is generally higher than that issued during a low-interest-rate environment.
Trade-Offs Among Life Annuities, RRIFs, and Segregated Fund GLWBs	life annuity vs. RRIF vs. GLWB	A life annuity eliminates the risk of outliving one's money but provides virtually no principal liquidity; an RRIF preserves investment growth and withdrawal flexibility but payments cease once assets are depleted; a segregated fund GLWB combines guaranteed lifetime proportional withdrawals with partial liquidity, though excess withdrawals permanently reduce the guaranteed base.
Death Benefit Trigger Sequence for Joint and Last Survivor Annuities	joint and last survivor annuity beneficiary trigger	Under a joint and last survivor annuity, upon the death of the first annuitant, the second annuitant continues receiving payments as the sole annuitant; any remaining balance under an attached guaranteed period becomes payable to designated beneficiaries only if the second annuitant also dies before the guaranteed period expires.
Taxation and Age Restrictions for ALDA and VPLA	advanced life deferred annuity (ALDA) & VPLA	An ALDA permits transferring up to 25% of a qualifying registered plan (proposed lifetime cap of $150,000 under the exam benchmark; $180,000 CRA limit in 2026) with payouts deferred up to the end of the year the annuitant turns age 85; a VPLA requires at least 10 members at establishment with an ongoing expectation to maintain that count, with an exam-benchmark payout commencement deadline of age 71 (current tax rules use the later of the end of the year turning 71 or the end of the year the right is acquired).

Self-test cues (Cornell left column)

1. Why is the distinction between immediate and deferred annuities based solely on when payments begin rather than deposit methods?
2. When a client has no estate needs and seeks maximum monthly income, why should a guaranteed period be omitted?

3. Under a joint and last survivor annuity with a 10–year guaranteed period, can the beneficiary claim funds if the first spouse dies in year 3?
4. After reporting taxes on an accrual basis during accumulation, can a non–registered deferred annuity switch to prescribed taxation upon entering payout?
5. Why must life insurance underwriting be completed before purchasing the annuity when structuring an insured annuity?

Summary: In three sentences, summarize how life annuities transfer longevity risk through mortality pooling, how guaranteed periods and tax rules impact cash flows, and how annuities and RRIFs complement each other in retirement planning.

Chapter 24 · Investor Profile: KYC, Risk Tolerance, Risk Capacity, and Suitability, and Why It Carries 35% of This Module

Segregated Funds & Annuities | P1 Must score | Investor Profile · 7 mock questions

Read with these questions: If a client claims to tolerate losses but has a fragile financial situation, does product allocation follow risk willingness or risk capacity?; When calculating CPP contributions for high-income earners, what is the difference between the exam syllabus and current 2026 rules?; Can an attorney acting under a Power of Attorney (POA) directly alter the beneficiary designation on a segregated fund?; If a young client is saving money to buy a home or attend school within three years, is the time horizon considered long or short?; What is the specific principle governing whether an individual product recommendation matches the client's profile?

How it is tested

- Willingness versus capacity conflict questions: Scenarios present a client who subjectively desires high returns or claims to tolerate steep losses, but has a fragile objective financial position (such as being the sole household earner, facing nondiscretionary short-term expenses, or relying solely on government pensions), testing whether candidates can recognize the independence of risk tolerance and risk capacity and apply the lower of the two as the binding upper constraint for recommendations.
- Time horizon and multi-goal separation questions: Scenarios use the client's chronological age (such as a client in their twenties or a retiree near age seventy) as a distractor, combined with short-term expenditure goals (such as funds needed within three years) or long-term intergenerational goals (such as grandchildren's education in twenty years), testing whether candidates determine the time horizon based on the specific goal of the funds rather than the client's age, and build separate investor profiles for different goals of the same client.
- Financial statements and debt classification questions: Scenarios provide details from a client's net worth statement, cash flow statement, and account statements, testing whether candidates identify that a reverse mortgage is an estate-eroding liability rather than an asset, that good debt still requires verifying ongoing repayment ability, and how to distinguish an explainable single-month large expenditure from ongoing structural deficit.
- Ongoing suitability and compliance documentation questions: Scenarios involve a client who completed an investor profile years earlier and experienced major life events such as divorce, job loss, or early retirement without contacting the agent, or an agent tempted by higher commissions, testing the ongoing review obligation under the suitability principle, the evidential protection of a reason-why letter, and the hierarchical distinction between suitability and Fair Treatment of Customers (FTC).

Traps (watch for the signal)

Deferring to client subjective preference: The question stem shows a client insisting on high-yield equity funds and claiming comfort with sharp market drops, while simultaneously revealing an inadequate emergency fund, sole breadwinner status, or reliance solely on pensions for living expenses.

Substituting age for time horizon: The question stem emphasizes the client's chronological age (such as 28 or 68), but immediately clarifies that the funds are allocated for a fixed near-term expenditure (such as a wedding in two years or tuition in three years) or a distant legacy goal (such as grandchildren's education in twenty years).

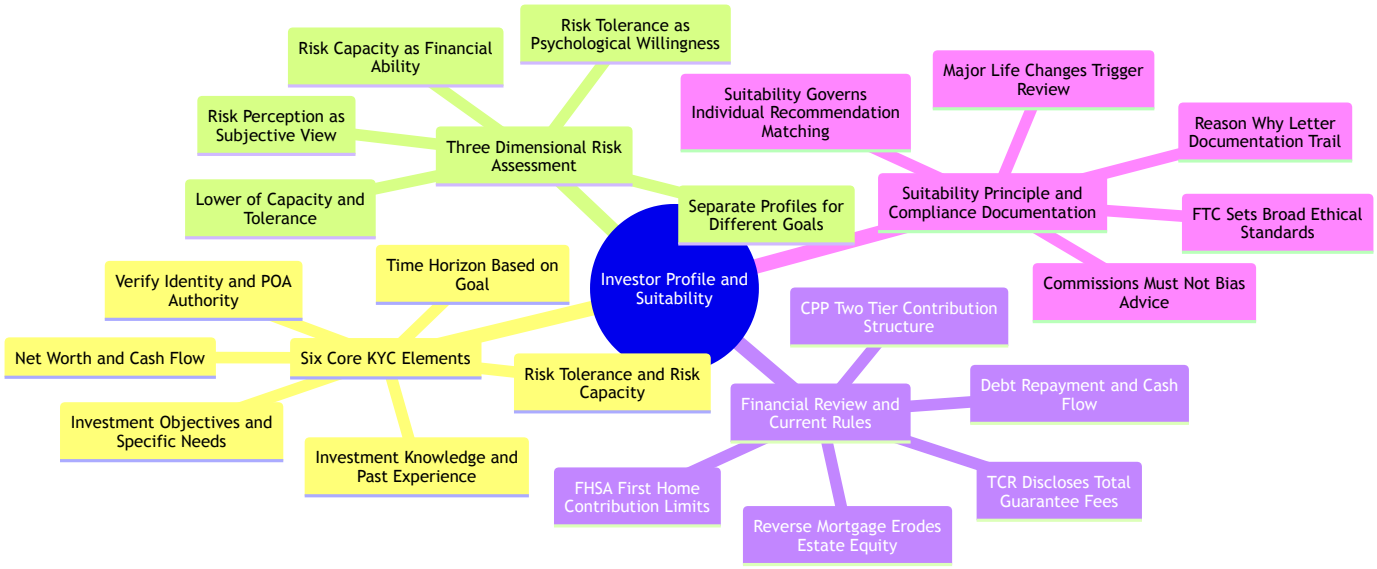
Extrapolating financial conclusions from portfolio holdings: The question stem provides only a net worth statement or conservative holding breakdown without complete information on income, expenses, age, or existing coverage, while options offer definitive conclusions like financial capacity is definitely low or life insurance is unnecessary.

Treating the profile as a one-time onboarding formality: The question stem notes that the client completed a profile several years ago and subsequently experienced a major life event such as retirement, divorce, an inheritance, or unemployment, without reaching out to update their records.

Exaggerating Power of Attorney authority: The question stem features an incapacitated client whose attorney under a POA presents the document and requests changing the existing segregated fund or insurance beneficiary to themselves or a third party without court authorization.

- Policy rules and legal boundary questions: Scenarios combine limitations on attorney authority under a Power of Attorney (POA) for property to change segregated fund (IVIC) beneficiary designations, CPP basic exemption and contribution ceilings, and verification documents for registered accounts such as RRSP, TFSA, and FHSA (like the Notice of Assessment, NOA), testing candidates' grasp of exam syllabus rules versus current BC statutory provisions (such as Power of Attorney Act s.20) and 2026 figures.

Mind map



Chapter 24Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Syllabus Weight for Assessing Client Needs and Situation	Assess the client's needs and situation (c1)	This competency component accounts for 35% of the Segregated Funds module exam syllabus, higher than analyzing products (30%) and implementing recommendations (25%), making it the only component weighted at more than one-third of total marks.
Six Core KYC Elements Requiring Independent Verification	Know Your Client (KYC)	Agents must independently verify identity, financial situation, investment objectives, time horizon, risk tolerance and capacity, and investment knowledge and experience, as none of these six elements can substitute for another.
Independent Assessment of Risk Tolerance versus Risk Capacity	Risk tolerance vs. Risk capacity	Risk tolerance is psychological willingness to endure volatility, while risk capacity is financial ability to absorb losses without compromising living goals; both must be evaluated separately, with the lower of the two acting as the binding upper limit for recommendations, whereas risk perception serves only as an interview clue.
Time Horizon and Goal-Oriented Profiling Principle	Time horizon & Investor profile	Time horizon is determined by when the money will be spent rather than the client's age, and because the same investor can have different risk tolerances for different financial goals, profiles must be constructed per goal rather than per person.
CPP Contribution Structure Under Exam Syllabus versus Current 2026 Two-Tier Standards	YMPE & YAMPE (CPP / CPP2)	The exam syllabus covers only a single tier from the $3,500 basic exemption to the Year's Maximum Pensionable Earnings (YMPE, $74,600 in 2026, maximum contributory earnings $71,100), whereas current 2026 rules add a second-tier ceiling, the Year's Additional Maximum Pensionable Earnings (YAMPE, $85,000), assessing CPP2 at 4% on the $10,400 band between YMPE and YAMPE (maximum annual contribution of $416 each for employee and employer).
Key 2026 Registered Account Limits and Verification Methods	RRSP, TFSA & FHSA limits	In 2026, the annual TFSA limit is $7,000 (cumulative room of $109,000 for individuals eligible since 2009, verified via actual contribution and withdrawal records across all institutions), the RRSP annual dollar limit is $33,810 (capped at 18% of prior year earned income and verified against the NOA, with a $2,000 lifetime non-deductible overcontribution buffer), and the FHSA annual limit is $8,000 (maximum single-year room of $16,000 including carry-forward, subject to a $40,000 lifetime cap).
Total Cost Reporting (TCR) Disclosure Requirements Specific to Segregated Funds	Total Cost Reporting (TCR) & IVIC	Effective January 1, 2026 and adopted in British Columbia, Total Cost Reporting (TCR) rules incorporate individual variable insurance contracts (IVICs), requiring disclosure of the fund expense ratio (%) and total fund expenses ($), as well as separate line-item disclosure of total guarantee fees ($) if not embedded in other fees, with the first annual statements under the new format delivered in early 2027.
Debt Classification and Accounting Treatment of Reverse Mortgages	Good debt, Bad debt & Reverse mortgage	Both good debt (mortgages, investment loans) and bad debt (consumer credit card balances) must be assessed on whether they can be serviced on schedule; a reverse mortgage must be repaid upon the homeowner's death or home sale and erodes estate equity, meaning it must be recorded as a liability rather than an asset during KYC.
Authority Boundaries of a Power of Attorney (POA) for Property Regarding Beneficiaries	Power of Attorney (POA) for property	An attorney under a Power of Attorney for property can manage, switch, or sell investments, but generally lacks authority to alter beneficiary designations on life insurance or segregated fund (IVIC) contracts; BC Power of Attorney Act s.20 mandates court authorization to change an existing designation, permits retaining the same beneficiary when renewing or replacing an instrument under specified conditions, and restricts new designations under fresh instruments to the grantor's estate.
Hierarchical Relationship Between the Suitability Principle and Fair Treatment of Customers	Suitability principle vs. Fair Treatment of Customers (FTC)	The suitability principle specifically governs ongoing alignment between investment features and the client's goals, constraints, and risk profile in an individual recommendation (uninfluenced by commissions or trailer fees), whereas Fair Treatment of Customers (FTC) serves as the overarching regulatory doctrine spanning seven obligations across the entire client lifecycle.

Self-test cues (Cornell left column)

1. What do each of the six core KYC elements verify, and why must agents not rely solely on a client's self-selected risk score?
2. When a client's risk tolerance exceeds their risk capacity, which one governs product recommendations as the binding limit?
3. What key updates do 2026 CPP2 (YAMPE), FHSA, and Total Cost Reporting (TCR) introduce compared to the 2022 exam syllabus?

4. When reviewing net worth statements and legal documents, what common pitfalls arise regarding reverse mortgages and Powers of Attorney (POA)?
5. What is the distinction between the suitability principle and Fair Treatment of Customers (FTC), and what events mandate a profile review?

Summary: In three sentences, summarize: how to construct goal–based investor profiles by independently verifying risk tolerance and risk capacity, and how to uphold suitability standards through reason–why letters and mandatory reviews following material life changes.

Chapter 25 · Segregated Fund and Annuity Recommendation: From Profile to Product, Application, and Reason–Why Letter

Segregated Funds & Annuities | P1 Must score | Recommendation · 7 mock questions

Read with these questions: When comparing segregated funds across categories or facing products with higher commissions, what disciplines must an advisor observe?; What is the difference between the sales charge options tested on the exam and the current ban on new DSC contracts and TCR guarantee cost disclosure?; In registered accounts and spousal RRSPs, who holds the contract owner, annuitant, and beneficiary designation rights?; When signing a segregated fund application form under a Power of Attorney for property, can the attorney also change the beneficiary on the client's behalf?

How it is tested

- Decision tree matching questions from profile to product: Given a client's objectives, time horizon, risk tolerance, and account type, scenarios test whether candidates can make compliant choices among payout annuities, individual segregated funds, accumulation annuities, and group segregated funds, focusing on matching product structural characteristics to the client's actual situation.
- Application form roles and authority boundary questions: Through scenarios where a client wants to name a younger spouse as the annuitant, a contributing spouse to a spousal RRSP wants to designate the beneficiary, or an agent completes the form on behalf of a client, scenarios test the statutory restrictions in registered accounts versus non–registered accounts regarding the contract owner, annuitant, and beneficiary.
- Special execution and representative authority questions: Scenarios involve an elderly, ill, or abroad client whose application form is signed by an attorney acting under a Power of Attorney (POA) for property, testing the strict distinction between the exception allowing signing the application and the authority to designate or change beneficiaries, as well as the difference between exam standard rules and current British Columbia statutory law.
- Three disclosure documents and rescission calculation questions: Combining the delivery milestones of the information folder, Fund Facts, and the original contract, scenarios test the two–business–day time limit for the right of rescission, the five–business–day deemed receipt triggering rule, and the calculation logic of refunding the lesser of the amount invested or the value on the next valuation date upon rescission.
- Reason–why letter and dual–standard compliance questions: Through scenarios involving verbal recommendations in a café, recommendations based solely on three–year past performance, or inquiries about sales charges and annual cost disclosure, scenarios test the five mandatory elements of a reason–why letter, the 'like' compared to 'like' principle, and the dual exam

Traps (watch for the signal)

Agent completion equated to agent decision trap: The question stem features an agent completing a segregated fund application form for a client, where the client has not personally provided certain information or where language and comprehension barriers exist, yet the agent proceeds toward signature.

Registered account role splitting trap: The question stem involves a registered account or a spousal Registered Retirement Savings Plan (spousal RRSP), and the client attempts to separate the contract owner from the annuitant, or have the contributing spouse designate the beneficiary.

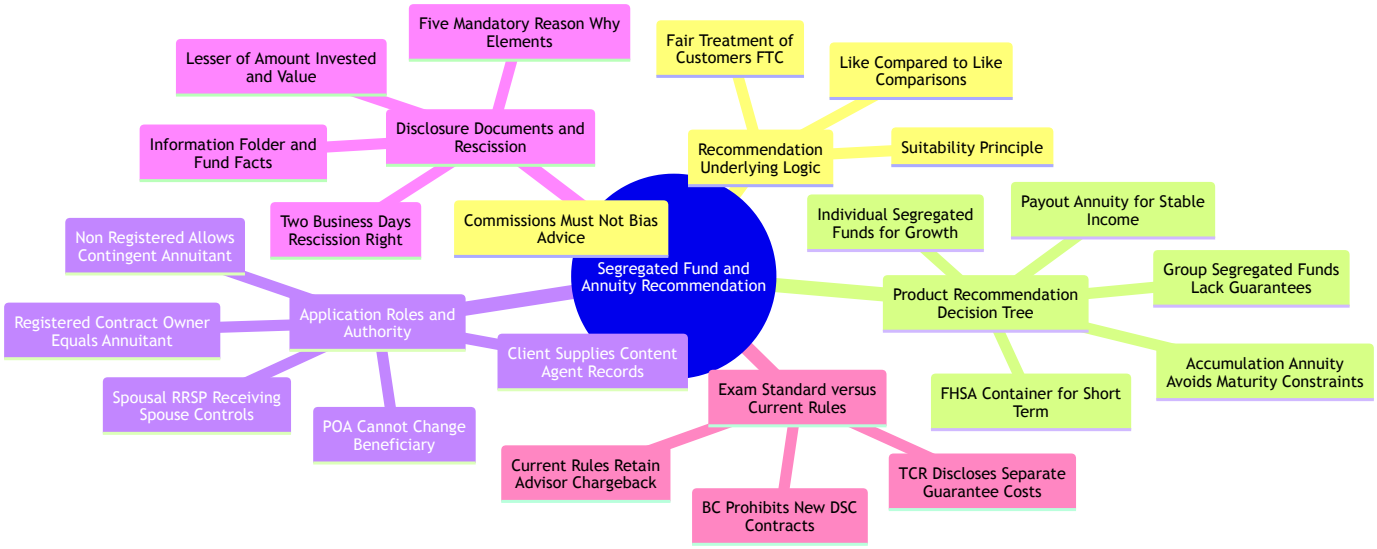
Power of Attorney exceeding authority to alter beneficiaries trap: The question stem simultaneously features an owner who is ill, incapacitated, or abroad having an application form signed by an attorney under a Power of Attorney (POA), alongside a request to designate or change the beneficiary.

Verbal assent substituting for reason–why letter trap: The question stem features informal communications, recommendations based solely on past performance, or a client verbally agreeing and signing without a written reason–why letter being documented and retained.

Product naming and dual–standard confusion trap: The question stem features a group segregated fund where the client requests death benefit principal protection, or asks about exam standard sales charge types or right of rescission calculations and deadlines.

versus current regulatory standards for the DSC ban and Total Cost Reporting (TCR).

Mind map



Chapter 25Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Suitability Principle and Like-Compared-to-Like Discipline	suitability principle & "like" compared to "like"	Commissions or trailer fees must never influence an advisor's judgment when making recommendations; when comparing fund performance or expenses, funds of the same category must be selected, and any cross-category comparison requires explaining the rationale to the client.
Dual Standards for Segregated Fund Sales Charges	sales charge (FEL / DSC / advisor chargeback)	The exam standard lists front-end load (FEL) and deferred sales charge (DSC) options side by side, noting that DSC is expected to be phased out; since June 1, 2023, British Columbia has prohibited new segregated fund contracts with DSC under the Financial Institutions Act, while the market retains advisor chargeback sales charge arrangements.
Total Cost Reporting and Guarantee Cost Disclosure	Total Cost Reporting (TCR)	The exam standard only covers disclosing the Management Expense Ratio (MER) and sales charges in annual statements; new Total Cost Reporting (TCR) rules effective January 1, 2026 require annual statements to disclose fund expense ratios as percentages, total fund expenses in Canadian dollars, and a separate dollar total for guarantee costs ($) if not already included in other fees.
Four Profile Dimensions and Recommendation Decision Tree	payout annuity / accumulation annuity / group segregated fund	Low risk tolerance seeking stable retirement income points to a payout annuity; saving conservatively without being constrained by a 10-year maturity or MER fluctuations points to an accumulation annuity; and group segregated funds provide no death benefit guarantee by default.
Providing Application Information and Handling Language Barriers	application form completion	The factual content of a segregated fund application form must be provided by the investor or a duly authorized person, while the advisor is responsible for recording, verifying, and explaining the information; if the client faces language or comprehension barriers, the advisor must wait until those barriers are resolved before proceeding.
Ownership Restrictions in Registered versus Non-Registered Contracts	contract owner & annuitant & contingent annuitant	In individual retirement registered contracts such as RRSPs, the contract owner and the annuitant must be the same person, and the contract cannot be transferred or pledged as collateral; in non-registered contracts, the owner and annuitant may be different individuals, and the contract may be transferred, pledged, or have a contingent annuitant designated.
Ownership Attribution in Spousal RRSPs	spousal RRSP	In a spousal Registered Retirement Savings Plan (spousal RRSP), the contributing spouse holds no ownership rights whatsoever; the spouse receiving the deposit is both the contract owner and the annuitant, and only that receiving spouse has the authority to designate beneficiaries.
Power of Attorney Execution Boundaries and Beneficiary Designations	Power of Attorney (POA) for property	When an investor is ill, mentally incapacitated, or abroad, an attorney acting under a Power of Attorney (POA) for property may sign the application form on their behalf, but the exam standard defaults to excluding the authority to designate or change beneficiaries from this exception (under British Columbia's current Power of Attorney Act s.20, altering an existing designation requires court authorization).
Three Disclosure Documents and Right of Rescission	information folder, Fund Facts & right of rescission	The advisor must deliver the information folder, review the Fund Facts for each chosen fund with the client, and deliver the contract; the client may exercise the right of rescission in writing within two business days of receiving the trade confirmation, receiving back the lesser of the amount invested or the fund value on the next valuation date.
Mandatory Reason-Why Letter and Its Five Core Elements	reason-why letter	A reason-why letter is not optional; it must be prepared during the application stage, reviewed with the client, and retained on file, and must contain confirmed facts, verified client instructions, identified addressed and unaddressed needs, explained suitability rationale, and evidence of client comprehension.

Self-test cues (Cornell left column)

1. Why is a reason-why letter mandatory in compliance investigations, and what five specific elements must it include?
2. In the recommendation decision tree, what client profile corresponds to each of payout annuities, individual segregated funds, accumulation annuities, and group segregated funds?

3. What are the fundamental differences among registered contracts (such as RRSPs), spousal RRSPs, and non-registered contracts regarding the contract owner, annuitant, and beneficiary designation authority?
4. When signing an application form under a Power of Attorney (POA) for property, why can the attorney not directly alter an existing beneficiary designation on the client's behalf?
5. How are the time limit and refund amount calculated for the right of rescission in segregated funds, and how do exam standard rules differ from current 2026 standards regarding DSC and TCR?

Summary: Summarize in three sentences: How to derive compliant product recommendations from the four investor profile dimensions, correctly establish the statutory authorities of owners, annuitants, and attorneys under a POA on the application form, and create a solid audit trail using the three disclosure documents and the reason-why letter.

Chapter 26 · Segregated Fund (IVIC) and Annuity Contracts: Clause–by–Clause Guarantees and Administration

Segregated Funds & Annuities | P2 Hold steady | IVIC & Annuity Contracts · 4 mock questions

Read with these questions: Can a registered segregated fund contract designate a contingent annuitant or be pledged as collateral for a bank loan?; Which contract elements are legally mandated or contractually fixed, and which are set at the insurer's discretion?; What changes occur regarding taxation and the maturity date when a non–registered contract executes a free switch that triggers a reset?; When a contract matures while the annuitant is incapacitated but living, who is entitled to claim the funds between an attorney under a POA and the beneficiary?; Can the named beneficiary immediately claim remaining funds when the first annuitant of a joint and last survivor annuity dies?

How it is tested

- Distinguishing contractually fixed or statutory guarantees from insurer administrative rules: Scenarios present conditions such as annual free switch limits, reset age ceilings, or irrevocable beneficiary changes, requiring candidates to determine which provisions are legally binding guarantees versus insurer–discretionary rules.
- Structural limitations of registered versus non–registered contracts: Presenting scenarios where a client wishes to designate a contingent annuitant or pledge a segregated fund contract as bank collateral, testing whether candidates know that only non–registered contracts permit role separation, collateral assignment, and contingent annuitants.
- Compounding consequences of switches and resets: Using fee–free switches in non–registered contracts as an entry point to evaluate capital gains tax dispositions (at a 50% inclusion rate) alongside the ripple effect of a 10–year maturity date extension triggered by a maturity reset.
- Applicant eligibility and documentation boundaries for maturity versus death claims: Testing who is entitled to claim, whether a death certificate or Attending Physician's Statement (APS) is required, and proportional guarantee base reductions from partial withdrawals across scenarios where an annuitant is incapacitated under a POA during their lifetime versus deceased.
- Annuity contract death benefit terms and anti–money laundering verification exemptions: Framing questions around beneficiary rights upon the primary annuitant's death under a joint and last survivor annuity, cancellation restrictions on payout annuities, and the compliance rule that registered pension transfers exempt identity verification but never proof of age.

Traps (watch for the signal)

The zero–consequence free switch trap: The question stem mentions a non–registered contract, free switch, market value exceeding original deposit, or a switch triggering a reset.

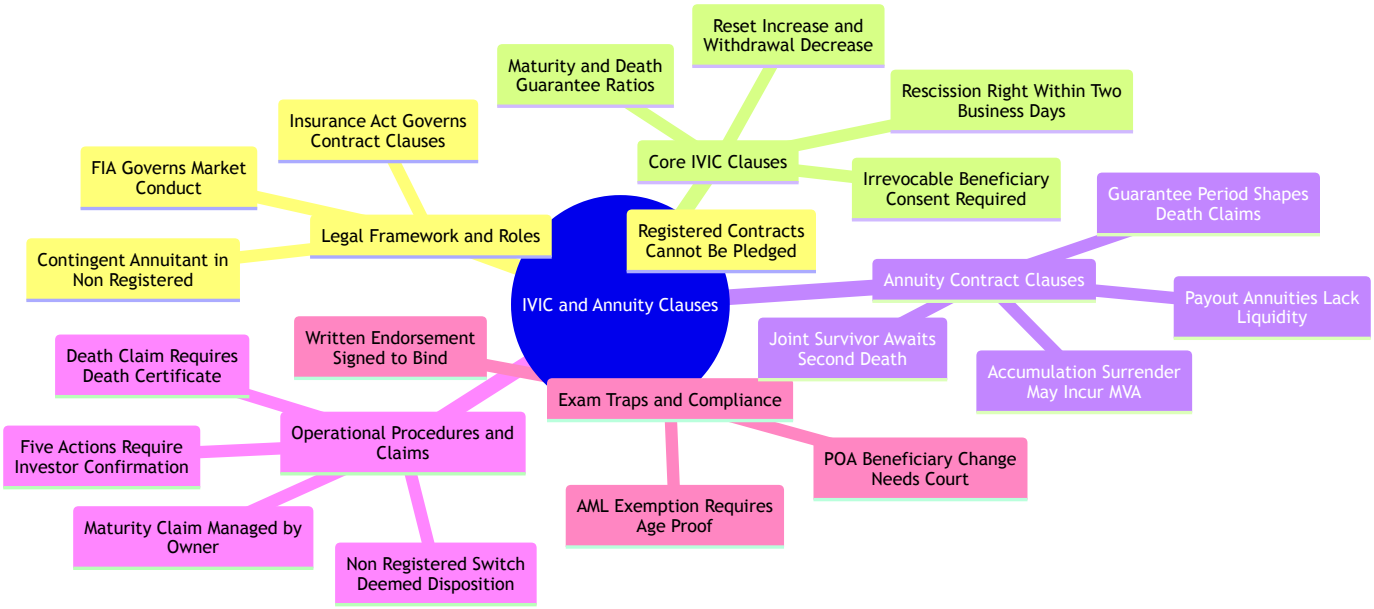
Mistaking lifetime incapacity for a death claim trap: The question stem mentions contract maturing soon, incapacitated owner/annuitant, Power of Attorney (POA), and a named beneficiary.

Naming a contingent annuitant on a registered contract trap: The question stem presents a registered segregated fund contract such as an RRSP, RRIF, or LIRA and asks about adding a contingent annuitant or pledging the contract as collateral.

Paying the beneficiary upon the first death in a joint annuity trap: The question stem mentions a joint and last survivor annuity, a guarantee period, and specifies that the first annuitant dies while the co–annuitant is still alive.

Broad POA beneficiary changes and age proof exemption trap: The question stem mentions an attorney under a POA wanting to change the beneficiary, or a registered pension transfer exempt from identity verification.

Mind map


IVIC and Annuity Clauses
Core IVIC Clauses
Reset Increase and Withdrawal Decrease
Maturity and Death Guarantee Ratios
Rescission Right Within Two Business Days
Irrevocable Beneficiary Consent Required
Registered Contracts Cannot Be Pledged
Legal Framework and Roles
Insurance Act Governs Contract Clauses
FIA Governs Market Conduct
Contingent Annuitant in Non Registered
Annuity Contract Clauses
Guarantee Period Shapes Death Claims
Payout Annuities Lack Liquidity
Joint Survivor Awaits Second Death
Accumulation Surrender May Incur MVA
Exam Traps and Compliance
Written Endorsement Signed to Bind
Operational Procedures and Claims
Death Claim Requires Death Certificate
Five Actions Require Investor Confirmation
Maturity Claim Managed by Owner
Non Registered Switch Deemed Disposition
AML Exemption Requires Age Proof
POA Beneficiary Change Needs Court

Chapter 26Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Statutory Division Between Contract Provisions and Market Conduct	Insurance Act Part 3 vs. Financial Institutions Act (FIA)	Segregated fund contract provisions themselves (beneficiary designation, creditor protection, and irrevocable beneficiary changes) are governed by Part 3 of the BC Insurance Act, whereas market conduct regulation such as ending DSC sales is enforced under the Financial Institutions Act (FIA).
Role Separation and Transfer Restrictions in Registered versus Non-Registered Contracts	Registered vs. Non-registered IVIC and Contingent Annuitant	Registered contracts legally require the contract owner and the annuitant to be the same person and cannot be assigned, pledged as collateral, or assigned a contingent annuitant; only non-registered contracts permit three-party separation, collateral assignment, and the naming of a contingent annuitant.
Right of Rescission and Refund Calculation Formula	Right of Rescission	An investor may rescind the contract in writing within two business days calculated from the earlier of actual receipt of confirmation or five business days after mailing; the refund equals the lesser of the amount invested and the fund market value on the valuation day following the rescission request.
Written Contract Amendments and Five Core Actions Requiring Confirmation	Amendment / Addendum and Investor Confirmation	Amendments or addenda to waive terms or correct errors must be prepared in writing by the insurer and signed by the policy owner to take effect, as verbal agreements are void; five core actions—purchase, switch, reset, withdrawal, and termination—strictly require investor confirmation.
Dual Benchmarks for the DSC Ban and Total Cost Reporting (TCR)	Deferred Sales Charge (DSC) and Total Cost Reporting (TCR)	The exam benchmark states DSCs are expected to be banned, whereas current BC rules prohibited issuing new DSC segregated fund contracts effective June 1, 2023 (allowing legacy contracts to run their schedules); Total Cost Reporting (TCR) rules mandate disclosing all fees, including insurance guarantee costs, in both percentages and actual dollar amounts on annual statements starting early 2027.
Switch Fees, Tax Dispositions, and Maturity Reset Extensions	Switch, Short-Term Trading Fee, and Reset	Switches made within 90 days of deposit may incur a short-term trading fee (illustrated as 2% on the exam), non-registered switches constitute a taxable disposition calculating capital gains regardless of whether the transaction is free, and triggering a maturity reset restarts the 10-year maturity period from the reset date (insurers often set an age ceiling such as age 80).
Ten-Year Maturity Renewal Options and Claim Procedure Distinctions	Maturity Claim vs. Death Claim	At 10-year maturity, the contract can be taken in cash, used to purchase an annuity, or renewed at the higher of market value or maturity guarantee; maturity claims are processed by the owner or attorney under a POA without a death certificate, whereas death claims require the beneficiary or estate representative to submit a death certificate or Attending Physician's Statement (APS).
Authority Boundaries for Attorneys Under a POA in Applications and Beneficiary Changes	Power of Attorney for Property (POA)	While an attorney under an enduring POA may sign applications and manage maturity claims, whether they may designate a beneficiary requires separate legal advice; under BC Power of Attorney Act s. 20, an attorney cannot alter the client's existing beneficiary designation without court authorization.
Death Benefit Payment Sequence for Joint and Last Survivor Annuities with Guarantee Periods	Joint and Last Survivor Annuity and Guarantee Period	Upon the death of the primary annuitant in a joint and last survivor annuity, the surviving co-annuitant becomes the sole annuitant and continues receiving income; the named beneficiary is entitled to claim remaining payments only after the second annuitant dies within the guarantee period (or if the contract includes a specific refund option).
AML Identity Verification Exceptions versus Mandatory Proof of Age for Annuities	FINTRAC Identity Verification Exception vs. Proof of Age	Although contracts funded directly and entirely by registered pension transfers, group life proceeds, or registered plans qualify for FINTRAC identity verification exceptions, proof of the annuitant's age is an essential contractual requirement and is never exempt under any circumstances.

Self-test cues (Cornell left column)

1. Which two British Columbia statutes respectively govern segregated fund contract provisions and the enforcement of the DSC ban?
2. Which contract terms are legally mandated or contractually fixed guarantees, and which are administrative rules set at the insurer's discretion?

3. Why are registered segregated fund contracts prohibited from designating a contingent annuitant or being pledged as loan collateral?
4. What two compounding consequences occur when a non-registered contract executes a fee-free switch that simultaneously triggers a maturity reset?
5. What are the core differences between maturity claims and death claims regarding claimant eligibility, POA authority, and required proof documents?

Summary: In three sentences, summarize: the boundaries between statutory or contractually fixed provisions versus insurer discretionary rules in segregated fund and annuity contracts; the dual tax and maturity date consequences of non-registered switches triggering resets; and the determination of claimant eligibility between maturity and death claims.

Chapter 27 · Group Retirement and Investment Plans: DB vs. DC Responsibilities and Post-CPP Enhancement Planning

Segregated Funds & Annuities | P3 Skim | Group Retirement · 1 mock questions

Read with these questions: When a plan sponsor outsources daily pension administration, who retains supervisory fiduciary responsibility under the prudent person rule?; Which three group plans generate a Pension Adjustment (PA) reducing next year's RRSP room, and how is it calculated?; To whom does the agent owe disclosure obligations in a group plan, and what is the sequence for setting up the plan?; How can a startup combine plans if it wants fixed-percentage contributions supplemented by variable profit sharing?; Do group segregated funds include death benefit guarantees, and which plans qualify as Capital Accumulation Plans?

How it is tested

- Matching six plan types to employer objectives: Scenarios present employer needs (such as contributing only in profitable years, allowing employees to make their own contributions, or avoiding actuarial funding liabilities), testing candidates on selecting the uniquely matching plan type using the two distinct criteria of contributor identity and bearer of investment risk.
- Calculating PA and RRSP contribution room: Given employee annual earnings and employer-employee matching contribution ratios in a DCPP or GRRSP, testing whether candidates distinguish which plans generate a Pension Adjustment (PA) reducing next year's RRSP room versus which plans directly consume current-year individual RRSP deduction limit.
- Termination fund transfers and locking-in rules: When employees handle account balances upon job change or retirement, testing the distinction between locked-in funds (transferred to a LIRA or LIF) and unlocked funds (transferred to an individual RRSP, RRIF, or cashed out), alongside the dual-benchmark differences between the exam standard of two-year vesting and current BC PBSA immediate vesting.
- Fiduciary duty and practical operational workflows: Testing whether a plan sponsor retains supervisory fiduciary duties under the prudent person rule after outsourcing administration, to whom an agent owes conflict-of-interest disclosure duties, and the two-stage plan implementation process where the sponsor applies first before individual members enrol.
- Tax treatment and eligibility red lines: Testing whether employer contributions to different plans constitute current taxable benefits to employees (taxable under a GRRSP or Group TFSA; non-taxable under a DCPP, DPSP, or PRPP), alongside strict eligibility restrictions such as barring employees owning 10% or more of voting shares from participating in a DPSP.

Traps (watch for the signal)

The contributory DPSP trap: The question stem mentions profit sharing alongside employees also contribute or contributory plan.

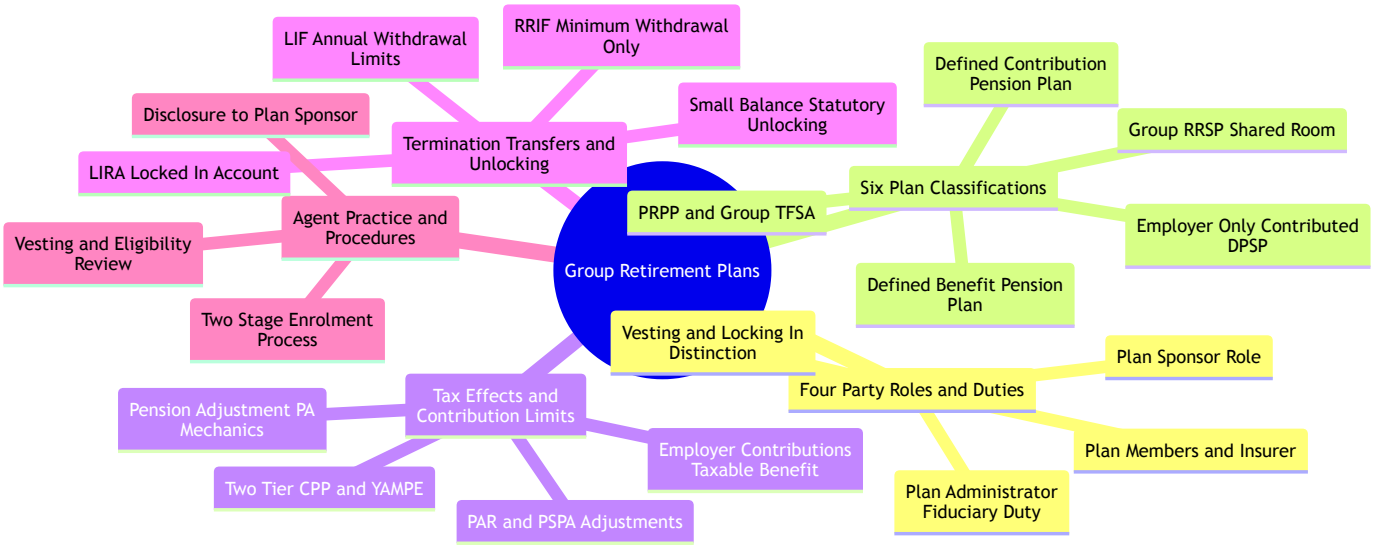
The universal PA coverage illusion: The question stem asks which plans generate a Pension Adjustment (PA) reducing next year's RRSP room, or provides GRRSP contribution amounts and asks for the resulting PA.

The tax-free employer contribution illusion: The question stem asks whether employer matching contributions are included in the employee's taxable income for the current tax year.

Confusing vesting with unlocking trap: The question stem describes an employee meeting vesting conditions upon termination and asks whether DCPP account balances can be directly withdrawn in cash.

Misaligning CAP definitions with guarantees trap: The question stem asks to identify a Capital Accumulation Plan (CAP) definition, or asks whether group segregated funds provide an automatic death benefit guarantee.

Mind map


Group Retirement Plans
Termination Transfers and Unlocking
LIF Annual Withdrawal Limits
RRIF Minimum Withdrawal Only
Small Balance Statutory Unlocking
Agent Practice and Procedures
Disclosure to Plan Sponsor
LIRA Locked In Account
Vesting and Eligibility Review
Two Stage Enrolment Process
PRPP and Group TFSA
Six Plan Classifications
Defined Contribution Pension Plan
Group RRSP Shared Room
Employer Only Contributed DPSP
Defined Benefit Pension Plan
Vesting and Locking In Distinction
Four Party Roles and Duties
Plan Sponsor Role
Plan Members and Insurer
Plan Administrator Fiduciary Duty
Tax Effects and Contribution Limits
Pension Adjustment PA Mechanics
Two Tier CPP and YAMPE
PAR and PSPA Adjustments
Employer Contributions Taxable Benefit

Chapter 27Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Plan Administrator Fiduciary Duty and the Prudent Person Rule	Fiduciary duty & Prudent person rule	The legal plan administrator of a pension plan governed by the PBSA owes a fiduciary duty to act in the best interests of plan members and beneficiaries under the prudent person rule, and cannot be relieved of its supervisory duty by outsourcing day-to-day investment management.
Contributory versus Non-Contributory Classification Boundary	Contributory vs. Non-contributory plan	Plans funded jointly by the sponsor and members are contributory, while plans funded solely by the sponsor are non-contributory; among the six group plans, only a DPSP is legally restricted to being non-contributory.
Legal Distinction Between Vesting and Locking-In	Vesting vs. Locking-in	Vesting determines employee ownership of accrued benefits (immediate vesting under current BC PBSA, while exam questions often cite a legacy two-year vesting rule), whereas locking-in mandates that funds remain dedicated to retirement income and cannot be freely withdrawn in cash.
DPSP Contribution Rules and Bar on Related Employees	Deferred Profit Sharing Plan (DPSP)	A DPSP is funded solely by the sponsor out of current or retained profits and is not locked in, but employees holding 10% or more of voting shares and individuals related to the employer are strictly barred from participating.
Taxable Benefit Status of Employer Contributions	Taxable benefit of employer contributions	Employer contributions to a GRRSP and a Group TFSA are included in the employee's current taxable employment income, whereas employer contributions to a DBPP, DCPP, DPSP, and PRPP are not considered current taxable income.
Pension Adjustment (PA) and Rebalancing Mechanisms	Pension Adjustment (PA), PAR & PSPA	Only DBPP, DCPP, and DPSP generate a Pension Adjustment (PA) that reduces the employee's next year's RRSP contribution room; early termination forfeitures restore room via a Pension Adjustment Reversal (PAR), while retroactive benefit upgrades create a Past Service Pension Adjustment (PSPA) that reduces available room.
CPP Base Tier and Second-Tier Enhancement (YAMPE)	YMPE & YAMPE (CPP2)	The exam standard tests only the first tier capped at the YMPE ($74,600 in 2026 with a $3,500 basic exemption); current rules add a second-tier YAMPE ($85,000 in 2026), where employer and employee each contribute 4% on the $10,400 band up to a maximum of $416.
Locked-In Transfer Vehicles: LIRA and LIF versus RRIF	LIRA & LIF vs. RRIF	Locked-in funds from a DCPP or PRPP upon termination transfer to a LIRA (for continued tax-sheltered growth without income) or a LIF (subject to statutory annual minimum and maximum withdrawal limits, unlike a RRIF which has only a minimum limit and no maximum).
Agent Disclosure Duties and Two-Stage Plan Implementation	Disclosure to sponsor & Two-stage enrolment	In group plans, the agent discloses representing insurers, compensation methods, and conflicts of interest directly to the plan sponsor; implementation follows a two-stage process where the sponsor applies first to establish the master plan, and members enrol individually after insurer underwriting approval.
Capital Accumulation Plan (CAP) Definition and Group Segregated Fund Features	Capital Accumulation Plan (CAP)	Any group retirement or savings plan where members select among two or more investment options constitutes a CAP (excluding a DBPP), and group segregated funds offered within such plans generally carry no default death benefit guarantees.

Self-test cues (Cornell left column)

1. What are the respective legal boundaries among the plan sponsor, administrator, member, and insurer, and can outsourcing daily management relieve the administrator of supervisory fiduciary duty?
2. How do DBPP, DCPP, DPSP, GRRSP, PRPP, and Group TFSA differ across the four core dimensions: who contributes, whether funds are locked in, whether employer contributions are taxable benefits, and whether a PA is generated?
3. How does a DCPP Pension Adjustment (PA) reduce next year's RRSP room, and how do GRRSP contributions impact an individual's RRSP deduction limit without generating a PA?
4. How do termination transfer destinations differ between locked-in DCPP funds and unlocked DPSP or GRRSP funds, and what is the distinction between LIF and RRIF withdrawal limits?
5. How should candidates switch between the exam standard (two-year vesting, single-tier CPP at YMPE) and current 2026 BC rules (immediate vesting, two-tier CPP with YAMPE) based on question stem cues?

Summary: In your own words, summarize: how to definitively classify the six group retirement plans using only three core criteria: whether employees can contribute, whether funds are locked in, and whether a Pension Adjustment (PA) is generated.

Chapter 28 · Legal Framework Governing Life Insurance: Which Law BC Actually Uses

Ethics & Professional Practice | P1 Must score | Legal Framework · 4 mock questions

Read with these questions: Is it illegal for an unlicensed assistant to phone prospective clients to book insurance appointments on behalf of an agent?; Is an application signed by a 100–year–old applicant legally valid, and can a 17–year–old purchase life insurance independently?; Must an agent report to FINTRAC if a client pays premiums using two $9,000 cash payments within a 24–hour window?; Can a daughter holding a photocopy of an Enduring Power of Attorney directly change the beneficiary to herself after her mother becomes incapacitated?; If a separation agreement bars beneficiary changes but an ex–husband secretly changes the beneficiary to his new spouse, to whom does the insurer pay the death benefit?

How it is tested

- Scenario characterization questions: Presenting daily actions of an agent or unlicensed assistant (such as phoning prospects to book appointments or verbally guaranteeing underwriting approval), testing which level of law governs the conduct and whether it constitutes ultra vires actions or unlicensed solicitation.
- Age and legal capacity distinction questions: Combining 15–, 16–, 18–, 19–, and 100–year–old applicants, testing whether candidates can distinguish legal capacity, the minimum statutory age to contract for insurance on one's own life, and the age required for a beneficiary to receive proceeds directly.
- Legal documentation authority and procedural workflow questions: Presenting a family member holding an ordinary Power of Attorney or a photocopy of an Enduring Power of Attorney demanding a beneficiary change, testing the four–step practical workflow, court authorization thresholds, and dual–benchmark distinctions.
- Inter–statutory conflict questions: When a separation agreement promises to maintain an ex–spouse as beneficiary but no irrevocable beneficiary designation was filed, testing whether family law agreements or Insurance Act discharge of insurer rules (s.77) take priority at the policy level.
- Perimeter compliance and public benefit screening questions: Combining split large cash premium payments, a self–employed client applying for Employment Insurance (EI) sickness benefits, or provincial client file management, testing the PCMLTFA 24–hour aggregation rule, PIPA jurisdictional boundaries, and public safety net gaps.

Traps (watch for the signal)

Equating provincial insurance regulation with total federal irrelevance trap: The question stem or options state that life insurance is governed solely by provincial legislation, or ask which level of law governs large cash reporting, genetic testing bans, or interprovincial data flows.

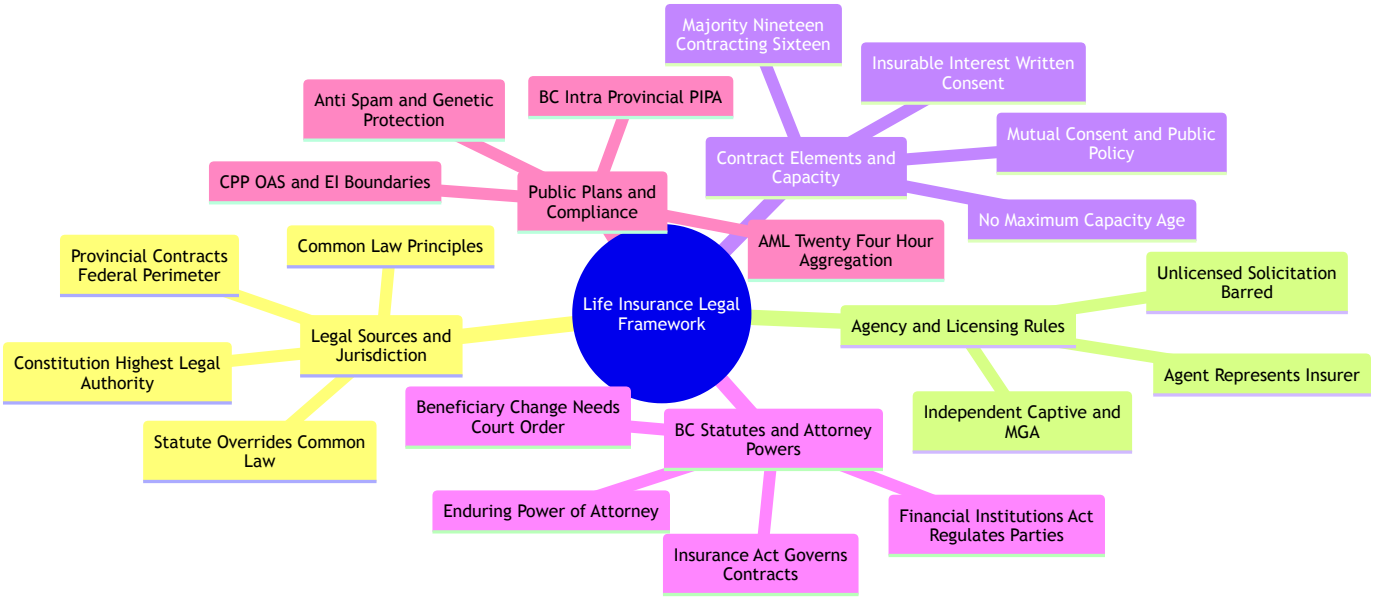
Assuming an unlicensed assistant only booking appointments commits no violation trap: The question stem describes an unlicensed assistant telephoning prospects to book appointments, receiving or forwarding applications, collecting premiums, or preparing life insurance illustrations.

Presuming elderly individuals lack contracting capacity trap: The question stem emphasizes that an applicant is 100 years old but mentally sharp, or presents ages such as a 16– or 17–year–old purchasing their own policy or an 18–year–old beneficiary collecting proceeds.

Assuming holding a Power of Attorney permits changing beneficiaries directly trap: The question stem describes a donor who is incapacitated by cognitive impairment, with a family member presenting an ordinary PoA or a photocopy of an Enduring PoA demanding to change the policy beneficiary to themselves.

Assuming a separation agreement automatically locks policy beneficiaries trap: The question stem describes an insured who signed a separation agreement promising not to change the beneficiary, but never registered an irrevocable designation with the insurer, subsequently changing the beneficiary online or in writing to a new spouse before dying.

Mind map


Life Insurance Legal Framework
Legal Sources and Jurisdiction
Common Law Principles
Provincial Contracts Federal Perimeter
Constitution Highest Legal Authority
Statute Overrides Common Law
Public Plans and Compliance
Anti Spam and Genetic Protection
BC Intra Provincial PIPA
CPP OAS and EI Boundaries
AML Twenty Four Hour Aggregation
Contract Elements and Capacity
Majority Nineteen Contracting Sixteen
Insurable Interest Written Consent
Mutual Consent and Public Policy
No Maximum Capacity Age
Agency and Licensing Rules
Unlicensed Solicitation Barred
Agent Represents Insurer
Independent Captive and MGA
BC Statutes and Attorney Powers
Beneficiary Change Needs Court Order
Enduring Power of Attorney
Insurance Act Governs Contracts
Financial Institutions Act Regulates Parties

Chapter 28Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Three-Tier Hierarchy of Legal Sources	Constitution / Common law / Statute law	The Constitution overrides federal and provincial statutes; common law governs general contract and agency principles, but statute law (such as provincial insurance acts) prevails over common law within its scope once enacted.
Agency Relationship and Prohibited Unlicensed Activities	Principal / Agent / Unlicensed staff	A life insurance agent represents the principal (the insurer) with authority circumscribed by the written agency contract; agency employees who solicit insurance, receive or forward applications, collect premiums, or prepare policy illustrations must be licensed.
Legal Capacity and Age Boundaries	Legal capacity / Age of majority	Legal capacity depends on whether an individual understands policy terms and the binding nature of the contract at execution, with no upper age limit (a 100-year-old is presumed capable); the BC age of majority is 19, but individuals aged 16 or older can contract for insurance on their own lives.
Insurable Interest and the Written Consent Exception	Insurable interest	BC Insurance Act s.45(1) provides that a contract is void if insurable interest is lacking when it takes effect, but s.45(2) explicitly exempts group insurance and cases where the insured consents in writing (or parental consent if under age 16).
Division Between BC Core Statutes and Regulatory Bodies	Insurance Act / Financial Institutions Act / BCFSA	The Insurance Act governs contract terms, while the Financial Institutions Act governs market conduct and institutions; BC insurers are regulated by BCFSA (which replaced FICOM), and life agents are licensed by the Insurance Council of BC.
Ordinary PoA versus Enduring PoA and Beneficiary Restrictions	Power of Attorney (PoA) / Enduring Power of Attorney	An ordinary Power of Attorney terminates upon the donor's mental incapacity, whereas an Enduring Power of Attorney must explicitly state it continues after incapacity; BC Power of Attorney Act s.20 mandates court authorization to change the donor's existing beneficiary designations.
Public Benefit Programs (CPP / OAS / GIS / EI)	CPP / OAS / GIS / Employment Insurance (EI)	The CPP is a mandatory contributory plan with equal employer-employee contributions; OAS is non-contributory and taxable, while GIS is a tax-free supplement for low-income OAS recipients; EI sickness benefits pay 55% of earnings up to 26 weeks (2026 weekly maximum $729), and self-employed individuals do not qualify for regular EI.
Privacy Law Division and Personal AML Reporting Duties	PIPEDA / PIPA / PCMLTFA / FINTRAC	Intra-provincial private-sector commercial activity in BC is governed by the substantially similar provincial PIPA, while cross-border data flows or federal works fall under PIPEDA; under the PCMLTFA, reporting duties rest personally upon the agent, with a $10,000 large cash threshold subject to a 24-hour aggregation rule.
Genetic Non-Discrimination and Human Rights Boundaries	Genetic Non-Discrimination Act (GNDA) / Bona fide grounds	The Genetic Non-Discrimination Act (GNDA) prohibits requiring genetic tests or disclosing test results as a condition of entering or maintaining an insurance contract; human rights legislation permits distinctions only where justified by bona fide and reasonable underwriting grounds.
Beneficiary Revocation, Discharge of Insurer, and Separation Agreements	Irrevocable beneficiary / Discharge of insurer	Unless an irrevocable designation is recorded and delivered (s.60), a subsequent designation overrides an earlier one (s.61); an insurer is fully discharged (s.77) upon paying the recorded beneficiary before receiving written notice of competing claims at its principal office.

Self-test cues (Cornell left column)

1. How are the Constitution, common law, and statute law hierarchically structured in life insurance, and which takes precedence in a conflict?
2. Which specific activities in an insurance agency require a license, and what is the fundamental difference between a life MGA and a P&C MGA?
3. How do BC rules treat ages 15, 16, 18, 19, and 100 regarding purchasing insurance, reaching the age of majority, and collecting proceeds as a beneficiary?
4. What four practical steps must an agent follow when a family member presents a Power of Attorney to change a beneficiary, and how does BC s.20 restrict the change?

5. How do the CPP, OAS, GIS, and EI differ in terms of funding sources, taxability, and eligibility for self-employed individuals?

Summary: In one sentence, summarize which statute governs BC life insurance contracts versus individuals and institutions, and state the agent's core compliance safeguards when handling Power of Attorney beneficiary changes and separation agreements.

Chapter 29 · Insurance Policy Provisions

Ethics & Professional Practice | P1 Must score | Policy Provisions · 4 mock questions

Read with these questions: Can an insurer still deny a claim and void the policy if the policy has been in force for over two years but medical history was deliberately concealed at application?; How will an insurer handle a claim if the applicant understated their age by three years and also omitted their smoking status on the application?; If a policy lapses for non-payment and is reinstated, how are exclusionary periods calculated if an insured event occurs within two years of reinstatement?; Can a policyholder unilaterally change an irrevocable beneficiary if their separation agreement explicitly states that each spouse waives rights to the other's insurance policies?

How it is tested

- Distinction questions on party status and authority: Presenting roles such as policyholder, life insured, irrevocable beneficiary, employer, or attorney under an Enduring Power of Attorney, testing who has the authority to change beneficiaries, apply for policy loans, or modify coverage limits.
- Determining contract formation and effective dates: Presenting multiple milestones such as submitting the application, paying the initial premium, underwriting ratings (counter-offers), changes in health status, and policy delivery, testing when the contract actually takes legal effect.
- Timeline deduction on statutory provision mechanics: Placing misstatement of age, innocent misrepresentation, intentional non-disclosure (fraud), suicide, death during the grace period, and policy reinstatement onto a two-year timeline, testing whether the insurer must deny the claim, refund premiums, or adjust the face amount.
- Scenario questions on beneficiary designations and creditor protection: Integrating separation agreements, change forms not delivered to head office, simultaneous death, or designating the estate as beneficiary, testing the entitlement to insurance proceeds and eligibility for statutory exemption from seizure by creditors.
- Comparative questions on national exam standards versus BC statutory law: Testing distinctions between national uniform exam standards and current BC statutory law regarding whether collateral assignment requires irrevocable beneficiary consent, the legal basis of the rescission period, policy replacement disclosure, and beneficiary changes under an Enduring Power of Attorney.

Traps (watch for the signal)

Mistaking a single milestone for the effective date trap: The question stem lists application, approval, delivery, and premium payment dates, or notes that underwriting modified policy terms (ratings, exclusions, reduced face amount) without signed client acceptance.

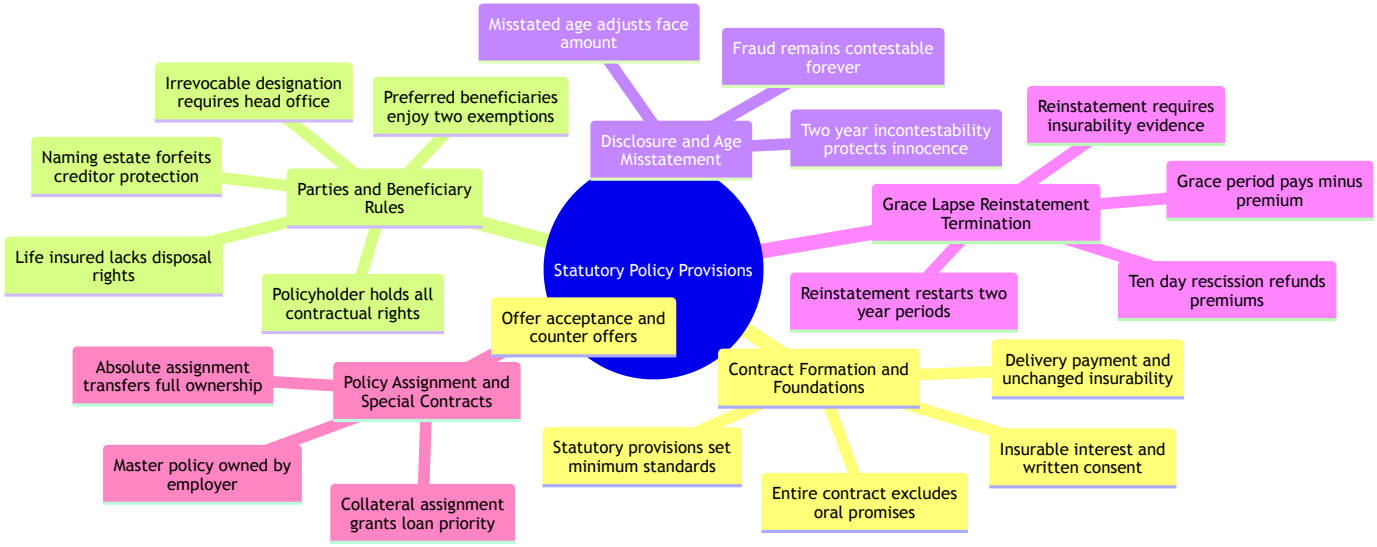
Confusing misstatement of age with health misrepresentation trap: The question stem combines an erroneous birth year with non-disclosure of smoking or health conditions, asking how the insurer will handle the claim upon discovery during investigation.

Assuming the incontestability period protects fraud trap: The question stem emphasizes that the policy has been in force for over two years while using phrases indicating subjective fraud such as knowingly, deliberately omitted, or intentional concealment.

Assuming divorce or handing forms to an agent changes the beneficiary trap: The question stem features a divorce agreement waiving policy rights or a change form left in an agent's drawer without reaching the insurer's head office, followed by the death of the life insured.

Overlooking that reinstatement restarts exclusionary periods trap: The question stem describes an older policy held for years that lapsed after missing the grace period, followed by suicide or discovery of material misrepresentation within two years of reinstatement.

Mind map


Statutory Policy Provisions
Disclosure and Age Misstatement
Misstated age adjusts face amount
Fraud remains contestable forever
Two year incontestability protects innocence
Parties and Beneficiary Rules
Irrevocable designation requires head office
Preferred beneficiaries enjoy two exemptions
Naming estate forfeits creditor protection
Life insured lacks disposal rights
Policyholder holds all contractual rights
Grace Lapse Reinstatement Termination
Reinstatement requires insurability evidence
Grace period pays minus premium
Ten day rescission refunds premiums
Reinstatement restarts two year periods
Contract Formation and Foundations
Offer acceptance and counter offers
Delivery payment and unchanged insurability
Insurable interest and written consent
Entire contract excludes oral promises
Statutory provisions set minimum standards
Policy Assignment and Special Contracts
Absolute assignment transfers full ownership
Master policy owned by employer
Collateral assignment grants loan priority

Chapter 29Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Entire Contract Principle	Entire contract	The application, policy, attached documents, and subsequent written endorsements together constitute the entire contract (BC Insurance Act ss.41, 42); verbal promises made by an agent are excluded from the contract.
Insurable Interest and Written Consent	Insurable interest	An insurable interest must generally exist when a contract takes effect, but group insurance or contracts where an adult life insured consents in writing are not void for lack of insurable interest (BC Insurance Act s.45); minors under 16 can be consented for by a parent.
Contract Formation and Counter-Offers	Counter-offer	By default, coverage requires policy delivery, initial premium payment, and unchanged insurability between application and delivery (BC Insurance Act s.48); if underwriting modifies terms (ratings or exclusions), it constitutes a counter-offer requiring client acceptance before taking effect.
Incontestability Period and Fraud Exception	Incontestability period	After a policy has been in force during the lifetime of the insured for two years, innocent misrepresentation no longer renders the contract voidable, but fraud (intentional non-disclosure) is never protected by the two-year incontestability period (BC Insurance Act ss.51, 52).
Misstatement of Age versus Misrepresentation of Smoking	Misstatement of age	Misstating age generally does not void the contract, but adjusts the death benefit to what the premiums paid would have purchased at the true age (BC Insurance Act s.54); misrepresenting smoking status is a material fact subject to policy rescission and the incontestability rules.
Grace Period and Reinstatement Timelines	Grace period & Reinstatement	Overdue premiums enjoy a minimum 30-day grace period (28 days for industrial insurance), during which death claims are paid minus overdue premiums (BC Insurance Act s.50); reinstatement within two years of lapse requires paying overdue premiums with interest and providing evidence of insurability, restarting both the incontestability and suicide periods from the reinstatement date (BC Insurance Act ss.56, 57).
Irrevocable Beneficiary Designations	Irrevocable beneficiary	An irrevocable designation takes effect only when filed in writing with the insurer's head office during the life insured's lifetime (BC Insurance Act s.60(1)); subsequent beneficiary changes, surrenders, or policy loans require the irrevocable beneficiary's written consent, and divorce does not automatically revoke the designation.
Two-Tier Exemption from Creditor Seizure	Exemption from seizure	Naming any beneficiary keeps death proceeds outside the estate and exempt from the policyholder's creditors (BC Insurance Act s.65(1)); naming a spouse, child, grandchild, or parent (preferred family class) also exempts the policy from seizure during the policyholder's lifetime (BC Insurance Act s.65(2)).
Insurer Payment Discharge and Simultaneous Death	Payment discharge & Simultaneous death	An insurer is fully discharged by paying according to its records before receiving contrary documentation at its principal office (BC Insurance Act s.77); when the life insured and beneficiary die simultaneously and the order of death is uncertain, the beneficiary is presumed to have died first (BC Insurance Act s.83).
Absolute Assignment versus Collateral Assignment	Absolute assignment & Collateral assignment	An absolute assignment transfers all policy ownership rights and may trigger a taxable policy disposition; a collateral assignment merely pledges the policy as loan security without triggering a disposition, granting the lender priority repayment for the unpaid loan balance at death (BC Insurance Act s.66).

Self-test cues (Cornell left column)

1. Why is a policy clause providing a 15-day grace period invalid, while a clause providing a 31-day grace period is legally valid?
2. What is the fundamental difference in the final step of contract formation between an approval as applied for and an approval with a rating?
3. Why does misstating age on an application result only in an adjusted face amount, whereas misstating smoking status can lead to claim denial and policy rescission?
4. Once an irrevocable beneficiary designation takes effect, how are separation agreements, policy surrenders or loans, and collateral assignments restricted?

5. When a policy lapses for non–payment and is subsequently reinstated, what effect does this have on the start dates of the incontestability and suicide periods?

Summary: In three sentences, summarize the hurdles a life insurance policy must clear from offer to taking effect, how misrepresentation and suicide outcomes are evaluated along a timeline at claim time, and how beneficiary designations and assignments determine who ultimately receives policy proceeds.

Chapter 30 · Claims and Payment of Proceeds

Ethics & Professional Practice | P1 Must score | Claims & Payment · 4 mock questions

Read with these questions: Is an insurer obligated to actively seek out beneficiaries after receiving notice of death, and when must payment be made within 30 days?; Must a family wait 7 years after an insured disappears before applying for a presumption of death, and what are the consequences of stopping premium payments?; How are life insurance proceeds and estate assets distributed when an insured and beneficiary die in the same accident with sequence uncertain or 3 days apart?; Within how many days must notice, claim forms, proof of claim, and loss–of–time payments be completed for individual A&S claims?; How should an insurer and an agent respond when a former spouse and a new beneficiary named in a will assert competing claims to insurance proceeds?

How it is tested

- Distinction questions on evidentiary requirements and the two time clocks: Presenting timelines where beneficiaries submit materials or delay legal action, testing the ability to distinguish between the client–protecting payment clock (payment within 30 days once all four items of sufficient proof are received) and the insurer–protecting limitation clock (the earlier of 2 years after submitting proof or 6 years after death, with a separate 2–year period following a declaration of presumption of death).
- Scenario questions on the dual standards for disappearance and presumption of death: Using circumstances such as hikers missing in the mountains or aviation disasters to test the exam standard general 7–year disappearance rule, exceptions where sufficient circumstantial evidence removes the waiting period (compared with the three criteria under BC Presumption of Death Act s.3 which has no fixed time requirement), and the core risk control requirement of continuing premium payments during the disappearance to keep the policy in force.
- Questions on simultaneous death and beneficiary priority: Designing scenarios where the life insured and primary beneficiary die at the same time or several days apart in the same accident, testing distribution determinations under Insurance Act s.83 (presuming the beneficiary died first in simultaneous death or uncertain sequence) and the explicit exclusion of the five–day survival rule under the Wills, Estates and Succession Act.
- Practical questions on competing claimants and the three safe harbours: When a former spouse and a new beneficiary named in a will assert competing claims, testing the preconditions for the record discharge rule (s.77 discharging the insurer for payments made per existing records before head office receives contrary written documents), payment into court (s.82 surrendering funds for judicial determination when admitting liability with adverse claimants), and a declaration as to sufficiency of proof (s.78), alongside the

Traps (watch for the signal)

Seven–year disappearance threshold and policy lapse trap: The question stem features a disappearance, air crash, or catastrophic accident, or mentions family members considering stopping premium payments during the absence.

Mistaking payment into court for claim denial trap: The question stem describes two or more claimants presenting conflicting designation documents to claim proceeds, or asks for the statutory remedy when an insurer admits liability but entitlement remains disputed.

Assuming a blanket 60–day A&S payment deadline trap: The question stem involves an individual A&S claim and differentiates between disability income or loss–of–time benefits versus a lump–sum non–loss–of–time benefit.

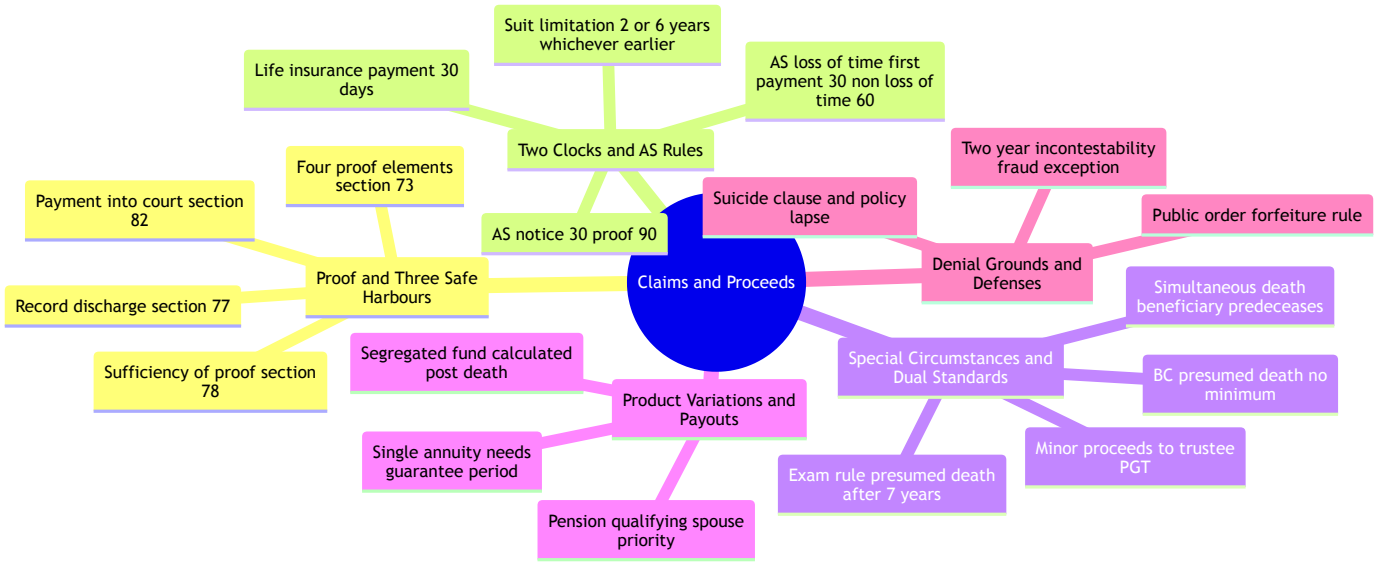
Applying the five–day survival rule to simultaneous death trap: The question stem involves both real property or estate assets and life insurance, or specifies that the life insured and beneficiary died sequentially (e.g., 3 days apart) from injuries in the same accident.

Assuming an unknowing beneficiary avoids public order forfeiture trap: The question stem emphasizes that the beneficiary who caused the death was unaware of being named beneficiary or did not commit the crime for insurance money, asking whether the insurer can refuse payment.

agent's professional duty to disclose conflicts objectively without predicting outcomes.

- Questions on claim denial defenses and cross–product payout rules: Combining suicide clauses, the 2–year incontestability period (except fraud), forfeiture for acts contrary to public order (regardless of beneficiary motive or knowledge), statutory condition timelines for individual A&S (30/15/90 days, and 30 days for initial loss–of–time benefits versus 60 days for non–loss–of–time), post–death segregated fund valuation, and single–life annuity guarantee periods to test which benefits are payable, to whom, and when.

Mind map



Chapter 30Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Four Proof of Claim Elements and the 30-Day Payment Clock	Proof of claim and 30-day payment period	Upon receiving sufficient proof of the occurrence of the insured event, the age of the life insured, the claimant's right to receive payment, and the name and age of the beneficiary, the insurer must pay the insurance money within 30 days (BC Insurance Act s.73).
Preconditions for the Three Safe Harbours	Payment into court / Sufficiency of proof	The record discharge rule (s.77) protects payments made per existing records before head office receives contrary documents; a declaration as to sufficiency of proof (s.78) resolves disputes solely over whether evidence is adequate; payment into court (s.82) strictly requires admitting liability to pay alongside statutory circumstances such as adverse claimants.
Limitation Clock for Legal Action	Limitation period	An action against an insurer for life insurance or A&S death proceeds must be commenced within the earlier of 2 years after furnishing proof of claim or 6 years after the date of death (ss.76, 104(1)); following a court declaration of presumption of death, a separate 2-year limitation period runs from the declaration date (s.76(2)).
Dual Standards for Disappearance and Presumption of Death	Presumption of death	The general exam rule provides that an application for a declaration of death can be made after 7 years of absence (with no waiting period where sufficient circumstantial evidence exists), whereas BC Presumption of Death Act s.3 applies three statutory criteria without a fixed time threshold; premiums must continue to be paid during the absence to keep the policy in force.
Dual Tracks of Simultaneous Death and the Five-Day Survival Rule	Simultaneous deaths / Five-day survival rule	Unless the contract provides otherwise, where the life insured and a beneficiary die at the same time or in circumstances where the order of death is uncertain, insurance proceeds are distributed as if the beneficiary predeceased the life insured (s.83), and the five-day survival rule under estate law (WESA s.10) is explicitly inapplicable to insurance money (WESA s.11).
Payment Channels for Minor Beneficiaries	Minor beneficiary / Public Guardian and Trustee	While exam materials note that some provinces may require payment into court, in BC the insurer must pay a minor beneficiary's proceeds in trust to a designated trustee, or to the Public Guardian and Trustee if no trustee exists (s.88); beneficiaries aged 18 or older are paid directly as adults (s.88(4)).
Statutory Condition Timelines for Individual A&S Claims	Notice and proof of claim (A&S)	Individual A&S requires written notice of claim within 30 days, insurer provision of claim forms within 15 days, and proof of claim within 90 days; the general exam rule requires payment within 60 days, whereas BC statutory conditions provide 60 days for non-loss-of-time benefits and 30 days for initial loss-of-time benefits, payable at least once every 60 days thereafter.
Death Benefit Features of Segregated Funds and Annuities	Segregated fund death benefit / Guarantee period	Segregated fund death benefits are calculated after death and fluctuate with market performance; a single-life annuity in the payout phase with no remaining guarantee period ceases with no further payments upon the annuitant's death; for pension-derived funds a qualifying spouse has priority over named beneficiaries.
Incontestability Period, Suicide, and Public Order Denials	Incontestability / Suicide / Public order	Innocent misrepresentation no longer renders a contract voidable after 2 years in force during the insured's lifetime, but fraud remains permanently contestable (s.52); suicide exclusion clauses are valid during the contracted period, typically 2 years from issue or reinstatement (s.56); an unlawful act causing the insured's death triggers public order forfeiture regardless of motive or knowledge, barring that specific beneficiary without voiding the underlying contract.
Agent's Role in Claims and the Three-Tier Dispute Escalation	Agent's role in claims / OLHI	An insurer has no statutory duty to proactively notify beneficiaries, and agents should assist in locating beneficiaries and explaining documentation requirements and the two clocks, but must never predict claim outcomes or take sides between adverse claimants; disputes escalate through internal complaints, the OmbudService for Life & Health Insurance (OLHI, providing independent recommendations without licensing or fining authority), and court litigation.

Self-test cues (Cornell left column)

1. Which four items of proof under BC Insurance Act s.73 must be fully satisfied to start the 30-day payment clock?

2. What are the respective preconditions for section 77 record discharge, section 78 declaration of sufficiency of proof, and section 82 payment into court?
3. What distinctions exist between the general exam standard and BC statutory law regarding presumed death from disappearance and individual A&S payment timelines?
4. Why do real estate and life insurance proceeds flow to different recipients when a beneficiary survives the life insured by three days following the same accident?
5. How is a life insurance claim handled when a beneficiary unlawfully causes the insured's death without knowing they were named as beneficiary?

Summary: In three sentences, summarize the core of this chapter: first, describe the four proof–of–claim hurdles and the two opposing time clocks (the 30–day payment deadline versus the earlier–of–2–years–or–6–years lawsuit limitation); second, outline the boundaries and preconditions of the three insurer safe harbours (ss.77, 78, and 82); and third, state the exam general rules versus BC statutory distinctions for disappearance, simultaneous death, and minor beneficiaries.

Chapter 31 · Bodies That Protect the Client

Ethics & Professional Practice | P2 Hold steady | Client Protection Bodies · 3 mock questions

Read with these questions: What are the respective regulatory mandates of federal OSFI and the provincial Insurance Council?; Which statute contains BC's provisions governing agent rebating and tied selling?; How are Assuris benefit protections calculated when an insurer becomes insolvent?; How does splitting cash payments trigger FINTRAC reporting under anti-money laundering rules?; Where should clients turn for claim dissatisfaction versus reporting agent misconduct?

How it is tested

- Institutional mandate matching questions: Given a specific scenario (such as an insurer solvency review, agent sales misconduct, or a client service dispute), candidates must determine whether OSFI, BCFSA, the Insurance Council of BC, or OLHI has jurisdiction, testing the division of responsibilities: the federal government regulates financial soundness, the province regulates individuals, complaints go to the ombudservice, and insolvencies are protected by the compensation fund.
- BC statutory source distinction questions: Asking which statute in BC contains the substantive provisions governing agent rebating, tied selling, licensing, and penalties, testing whether candidates avoid the literal distraction of the Insurance Act and correctly choose the Financial Institutions Act (FIA).
- Assuris insolvency protection calculation and procedural order questions: Given a policy's death benefit, cash value, or monthly income amount, candidates must calculate the protected benefits based on whichever is higher between the fixed dollar threshold and the percentage, or evaluate the procedural order where the liquidator first attempts to transfer policies and Assuris provides protection only if benefits are cut.
- FINTRAC anti-money laundering threshold and deadline questions: Scenarios centered on the $10,000 cash or virtual currency threshold, the 24 consecutive hour aggregation rule (24-hour rule), and different submission deadlines for Suspicious Transaction Reports (STR) and Large Cash Transaction Reports (LCTR), testing whether candidates confuse the aggregation trigger window with the submission reporting deadline.
- Interprovincial coordination and cross-sectoral jurisdictional boundary questions: Testing whether CISRO and CCIR possess legislative powers, or distinguishing between segregated funds and mutual funds regarding regulatory oversight (insurance regulation vs CIRO) and insolvency protection funds (Assuris vs CIPF).

Traps (watch for the signal)

Misallocating Federal and Provincial Jurisdiction (OSFI vs Provincial Bodies): When the stem mentions individual practice terms like 'licensing', 'agent misconduct', or 'disciplinary action', look for the Insurance Council of BC; when it mentions 'financial soundness of federally registered insurer', look for OSFI; when it mentions 'business authorization in BC', look for BCFSA.

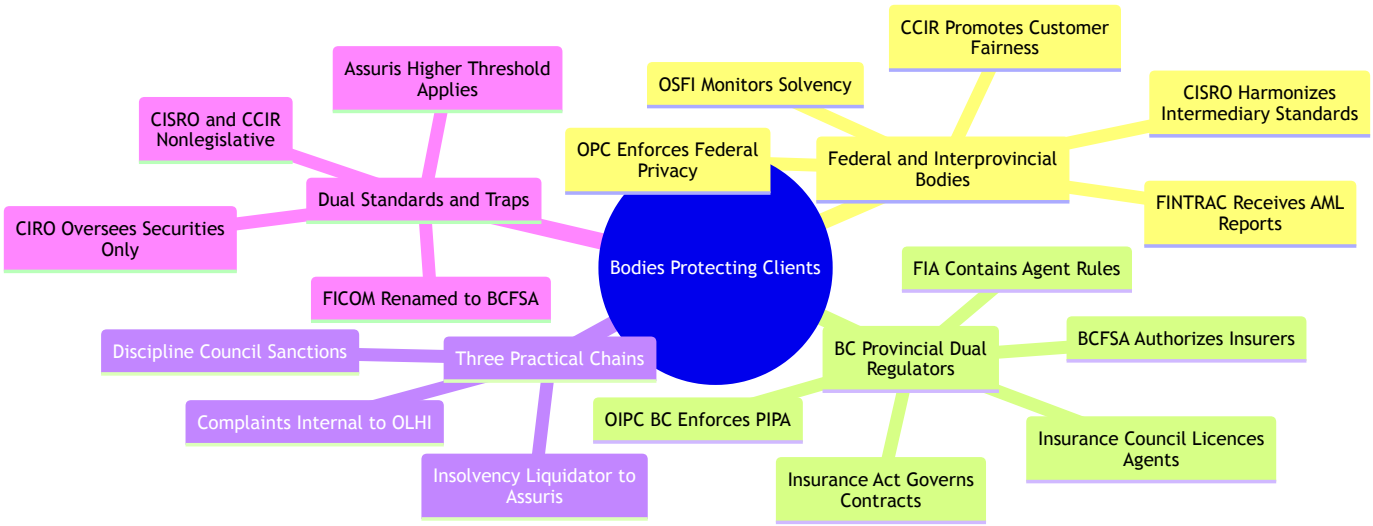
Confusing BC Insurance Act with Financial Institutions Act (Insurance Act vs FIA): When the stem mentions 'British Columbia' alongside 'statutory provisions governing agents / rebating / tied selling', the answer must point to the Financial Institutions Act, not the Insurance Act.

Overstepping Authority Between Dispute Mediation and Discipline (OLHI vs Insurance Council): When the stem asks to 'revoke licence / impose fine', choose the provincial regulator (Insurance Council); when it asks about an 'unresolved dispute after receiving a final position letter', choose OLHI.

Inverting Assuris Protection Limits or Reversing Procedural Order: When the stem mentions 'insurer insolvency / Assuris protection', first check if it tests automatic coverage and the liquidator's transfer order; if calculating an amount, use max(fixed threshold, percentage * original benefit) not exceeding the original contractual benefit.

Confusing FINTRAC 24-Hour Aggregation Window with Reporting Deadlines: When the stem presents multiple transactions under $10,000 that total $10,000 or more, focus on 'within 24 consecutive hours' to verify triggering; when asked 'when must the report be submitted', apply the specific deadline for that report type.

Mind map


Bodies Protecting Clients
Federal and Interprovincial Bodies
CCIR Promotes Customer Fairness
OSFI Monitors Solvency
CISRO Harmonizes Intermediary Standards
OPC Enforces Federal Privacy
FINTRAC Receives AML Reports
Dual Standards and Traps
Assuris Higher Threshold Applies
CISRO and CCIR Nonlegislative
CIRO Oversees Securities Only
FICOM Renamed to BCFSA
BC Provincial Dual Regulators
FIA Contains Agent Rules
BCFSA Authorizes Insurers
Insurance Council Licences Agents
Insurance Act Governs Contracts
OIPC BC Enforces PIPA
Three Practical Chains
Discipline Council Sanctions
Complaints Internal to OLHI
Insolvency Liquidator to Assuris

Chapter 31Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Core Division Between OSFI and Provincial Regulators	financial soundness vs licensing and market conduct	Under the Insurance Companies Act, OSFI monitors the financial soundness (solvency) of federally registered life insurers, and does not licence, regulate, or discipline insurance agents.
Jurisdictional Boundary Between BC's Two Insurance Regulators	BCFSA business authorization vs Insurance Council licensing	In BC, BCFSA (which replaced FICOM) issues business authorizations to insurers, while the Insurance Council of BC licences individual agents and corporate agencies and enforces Council Rules and the Code of Conduct.
Statutory Source of Substantive Agent Regulation in BC	Financial Institutions Act (FIA) vs Insurance Act	The BC Insurance Act has no dedicated chapter on agents; statutory provisions prohibiting premium rebating (s. 79), prohibiting tied selling (s. 94), governing agent licensing (ss. 168–180), and prescribing penalties are set out in the Financial Institutions Act (FIA).
Coordinating Role of CISRO and CCIR	Fair Treatment of Customers (FTC) and non-legislative bodies	CISRO and CCIR are inter-jurisdictional coordinating bodies that cannot enact legislation or regulations, but jointly issued the Fair Treatment of Customers (FTC) guidance applicable to both insurers and intermediaries.
Assuris Insolvency Protection Procedural Order and Calculation Rules	liquidator policy transfer and Assuris coverage limits	When an insurer becomes insolvent, the liquidator first attempts to transfer policies, and Assuris protection applies automatically without application; if benefits are cut, protection covers whichever is higher between the fixed floor and percentage (2022 exam standard: death benefit $200,000 or 85%; 2026 current standard: $1,000,000 or 90%).
FINTRAC Agent Obligations and Reporting Deadlines	reporting entity, 24-hour rule, LCTR and STR	As reporting entities, life agents must implement compliance programs, keep records, verify identities, and report transactions; cash or virtual currency totaling $10,000 or more within 24 consecutive hours triggers reporting: LCTR within 15 calendar days, LVCTR within 5 business days, and STR as soon as practicable.
Application Boundary Between Federal and BC Privacy Laws	PIPEDA vs PIPA (BC) and OIPC BC	BC has its own private-sector privacy statute, PIPA (enforced by OIPC BC), deemed substantially similar to federal PIPEDA; commercial activity within BC is generally governed by PIPA, while interprovincial or international commercial personal information transfers may trigger PIPEDA.
Prerequisites for OLHI Independent Dispute Resolution	final position letter and OLHI mandate	Before submitting a complaint to the national independent dispute body OLHI, a client must exhaust the insurer's internal complaints process and obtain a final position letter; OLHI has no statutory power to revoke licences or levy fines.
Regulatory and Protection Division Between Segregated Funds and Mutual Funds	segregated funds vs mutual funds (CIRO and CIPF)	Segregated funds are insurance contracts governed by provincial insurance regulators and protected against insolvency by Assuris; mutual funds are securities regulated by CIRO (formed by merging MFDA and IIROC) and protected by CIPF.
BC Licensed Agent Supervision, E&O, and Continuing Education Requirements	24-month supervision, E&O limits, and 15 CE credits	New BC licensees must practice under a qualified supervisor for 24 months (reduced to 12 months for CLU, CFP, or RFP holders), maintain E&O coverage of at least $1,000,000 per claim and $2,000,000 aggregate, and complete 15 CE credits per licence period while retaining records for 5 licence periods.

Self-test cues (Cornell left column)

1. Why does OSFI focus solely on insurer financial soundness rather than licensing or disciplining individual agents?
2. Under which statute does BC penalize agent premium rebating and tied selling: the Insurance Act or the Financial Institutions Act?
3. When clients encounter service disputes, agent misconduct, or insurer insolvency, what are the initial entry points and ultimate resolving bodies for each?
4. How is the Assuris 'whichever is higher' rule calculated between the fixed dollar floor and percentage, and how do 2022 exam values differ from 2026 current standards?
5. What is governed by the FINTRAC $10,000 24 consecutive hour rule, and what are the filing deadlines for LCTR, LVCTR, and STR?

Summary: Summarize this chapter in three sentences: First, state the division between federal and BC provincial bodies regarding financial soundness versus licensing and conduct; second, identify the corresponding bodies for complaints, agent misconduct, and insurer insolvency; third, highlight the two most critical differences in figures or institutional names between the 2022 exam standard and 2026 current rules.

Chapter 32 · Main Responsibilities of Life Insurance Agents

Ethics & Professional Practice | P1 Must score | Agent Duties · 5 mock questions

Read with these questions: When an installment policy costs only $2,000 per payment, at what point must anti–money laundering identity verification be completed?; If a client is in a rush to leave for vacation, can the Life Insurance Replacement Declaration (LIRD) be signed without the written comparison discussion?; Upon arriving to deliver a policy, the agent discovers the client was just hospitalized for tests; can the agent proceed with delivery?; What violation occurs when replacing an existing client's term policy with whole life from another insurer while failing to disclose the risks?

How it is tested

- Scenario characterization questions: Given specific agent conduct such as inducing policy replacements, fronting, handling client cash, or defaming competitors, candidates must precisely distinguish between churning and twisting, or determine which category of prohibited practices has been violated.
- Process sequence and audit trail questions: Focusing on the six–step needs analysis method, the policy replacement LIRD process, or the pre–delivery health review, testing whether written records can be omitted or steps skipped when a client is in a hurry or when the outcome appears suitable.
- Anti–money laundering KYC threshold and verification method questions: Testing the $10,000 cumulative policy duration threshold, the 30–day verification window after creating an information record, the beneficiary verification deadline before the first payment, exempt policy categories, and the exclusion of non–statutory instruments such as credit cards or cheques.
- E&O coverage scope and practice compliance questions: Testing the boundary where Errors and Omissions (E&O) insurance excludes intentional fraud and forgery, BC minimum policy limits, automatic licence suspension after 30 days of lapsed coverage, the 5–business–day lapse reporting obligation, and post–departure run–off insurance.
- Complaint handling and dual–standard distinction questions: Testing that any verbal dissatisfaction constitutes a complaint, complaint log retention requirements, and the boundaries between national exam standard and BC provincial rules (such as the exception for rebating strictly under 25%, and the withdrawal of Guideline G19).

Traps (watch for the signal)

Confusing Churning with Twisting: Check the insurers of the existing and new policies in the question stem: replacing a policy within the same insurer is churning, while inducing a switch across different insurers with hidden or misleading costs is twisting.

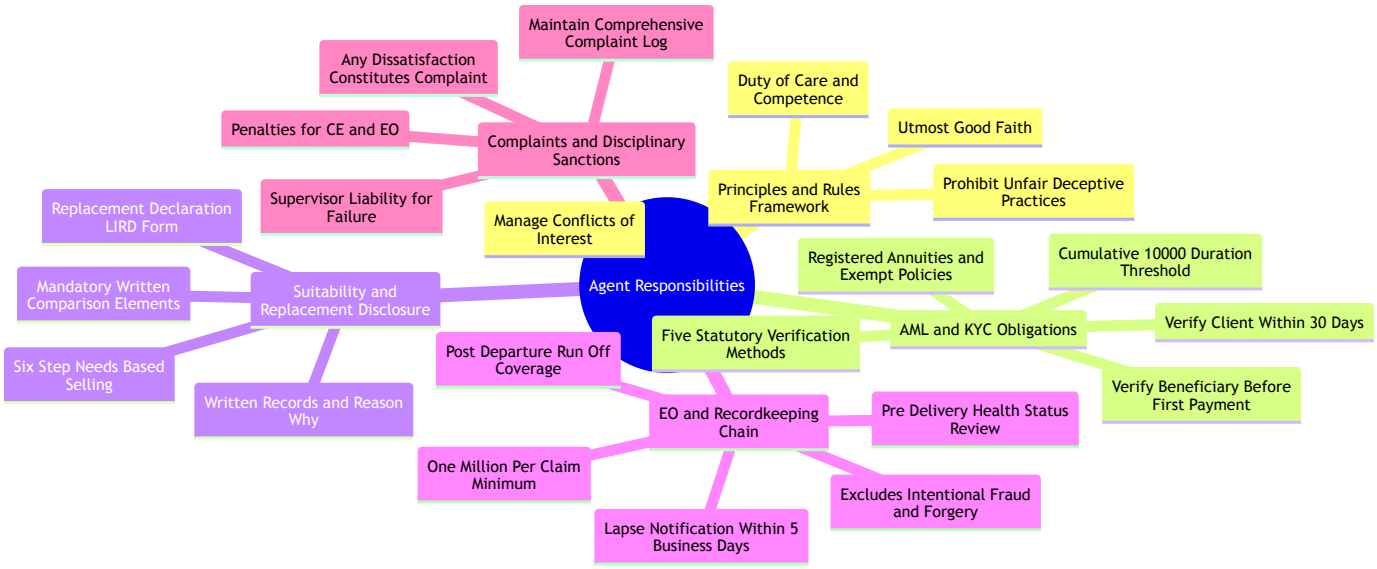
Treating the $10,000 KYC Verification Threshold as a Single–Payment Amount: Look for installment premiums (such as $2,000 annually or per installment) where total expected payments over the policy or annuity duration reach $10,000, or where credit cards or personal cheques are improperly offered to replace statutory verification methods.

Assuming Written Records Can Be Omitted if the Product Fits or the Client Is in a Hurry: When the stem emphasizes that the recommended product objectively suits the client, that the client is rushing for a vacation, or that the agent acted for the client's good, attempting to justify skipping fact–finding, written records, or the written LIRD comparison.

Treating E&O Insurance as an All–Purpose Shield or Treating 30 Days as a Grace Period: When the stem involves intentional acts such as forgery or misappropriation of client funds seeking E&O coverage, or failing to notify the Council within 5 business days after an E&O lapse.

Applying Withdrawn Guideline G19 or Assuming Principle–Level Breaches Only Draw Warnings: When options cite CLHIA Guideline G19 as authority for current commission disclosure, or assert that breaching utmost good faith or blindly trusting automated spreadsheet figures as a supervisor draws only a verbal warning.

Mind map


Agent Responsibilities
Complaints and Disciplinary Sanctions
Maintain Comprehensive Complaint Log
Any Dissatisfaction Constitutes Complaint
Penalties for CE and EO
Supervisor Liability for Failure
Principles and Rules Framework
Duty of Care and Competence
Utmost Good Faith
Prohibit Unfair Deceptive Practices
Manage Conflicts of Interest
Suitability and Replacement Disclosure
Replacement Declaration LIRD Form
Mandatory Written Comparison Elements
Six Step Needs Based Selling
Written Records and Reason Why
Registered Annuities and Exempt Policies
Five Statutory Verification Methods
AML and KYC Obligations
Cumulative 10000 Duration Threshold
Verify Client Within 30 Days
Verify Beneficiary Before First Payment
Post Departure Run Off Coverage
EO and Recordkeeping Chain
Pre Delivery Health Status Review
One Million Per Claim Minimum
Excludes Intentional Fraud and Forgery
Lapse Notification Within 5 Business Days

Chapter 32Key points (cover the right two columns to self-test)

Key points	Exam term	Rule / number
Two-Tier Normative Framework: Principles and Rules	Principles vs Rules / Utmost good faith	Principles govern how agents must act in good faith, while rules prescribe prohibited conduct; breaching principles such as integrity, competence, or conflicts of interest likewise leads to serious disciplinary consequences, and penalty severity cannot be presumed based on textbook classification.
Anti-Money Laundering Identity Verification Threshold and Deadlines	Know your client (KYC) / Information record	When total payments expected over the entire duration of a policy or annuity reach $10,000, client identity must be verified using one of five statutory methods (credit cards or cheques cannot be used) within 30 days of creating the information record; if cumulative payments to a beneficiary are expected to reach $10,000, identity must be verified before the first payment.
Needs Analysis and Written Documentation	Needs-based sales practices / Reason-why letter	The best-practice sequence requires initial disclosure, understanding expectations, fact-finding, needs assessment, providing recommendations, and explaining product information; agents must maintain written records of the needs analysis and reasons for recommendation, and skipping fact-finding or lacking written records breaches suitability principles.
Policy Replacement Disclosure Obligations	Disclosure about replacement / LIRD	When replacing an existing policy, the agent must complete the Life Insurance Replacement Declaration (LIRD) and a written comparison explaining policy differences, replacement rationale, inherent risks, cash values, and tax consequences, discuss them in person point by point, and provide copies to the client, with no exemption for time pressure.
Current Authority for Commission Disclosure	Commission disclosure / CLHIA G13 & G14	CLHIA Guideline G19 was withdrawn in its entirety on May 31, 2019, and never took full effect; current disclosure is governed by the exam standard section 4.2.4.1 checklist (companies represented, method of compensation, additional compensation, conflicts of interest) and the BC Code of Conduct.
E&O Coverage Limits, Scope, and Consequences of Lapsed Coverage	Errors and omissions (E&O) insurance / Run-off insurance	BC requires maintaining Errors and Omissions (E&O) insurance with minimum coverage of $1,000,000 per claim and $2,000,000 aggregate, covering only negligence, errors, and omissions while excluding intentional fraud or forgery; an E&O lapse must be reported to the Council within 5 business days, coverage lapsed beyond 30 calendar days results in automatic licence suspension, and retiring or departing agents should arrange run-off coverage.
Pre-Delivery Health Status Review	Policy delivery / Change in insurability	Before delivering the policy contract, the agent must reconfirm the client's health status; if a material change in insurability occurs between application signing and delivery, the agent must not deliver the policy under the original terms, but must withhold delivery and refer the file to the insurer for reassessment.
Complaint Definition and Complaint Log Management	Complaint log	Any expression of dissatisfaction by a client regarding service (whether verbal or written, and with or without financial loss) constitutes a complaint; agents must distinguish general service complaints from ethical breaches under the Code of Conduct and record the entire process in a complaint log for regulatory audit.
Churning, Twisting, and Fronting	Churning / Twisting / Fronting	Churning is unnecessarily replacing a policy within the same insurer to generate commission, twisting is inducing a policy replacement across different insurers through misleading representations, and fronting is submitting business under a licensee's name when that licensee had no direct contact with the client; all three constitute serious prohibited practices.
Client Fund Segregation and Boundaries for Rebating and Referrals	Misappropriation of client funds / Premium rebating / Referral fee	Depositing client cash premiums into an agent's personal bank account for forwarding is strictly prohibited; while national exam standard classifies premium rebating as an unfair practice, BC permits rebating that is strictly less than 25% of the premium provided it is in the client's interest and conforms to contract terms, whereas paying a referral fee to an unlicensed person requires that they engage in no insurance activities and that written disclosure is provided prior to the transaction.

Self-test cues (Cornell left column)

1. How is the FINTRAC $10,000 threshold calculated for client and beneficiary identification, what are the respective deadlines, and which methods are legally valid?
2. What is the correct sequence of the six-step needs analysis process, and why does recommending the right product without written documentation still constitute a violation?
3. When a policy replacement is triggered, what specific elements must be included in the written comparison accompanying the Life Insurance Replacement Declaration (LIRD)?
4. What are the minimum E&O insurance coverage limits in BC, what conduct is excluded, and what rules correspond to 5 business days versus 30 calendar days after a coverage lapse?
5. What are the core distinctions between churning, twisting, and fronting, and what are BC's specific rules regarding premium rebating and referral fees to unlicensed individuals?

Summary: In three sentences, summarize: across the five chains of agent obligations—KYC, suitability assessment, policy replacement, complaint handling, and E&O with pre-delivery review—at what specific milestones must an agent take action and what written documentation must be retained?