LLQP Question Book

224 main questions plus 224 variants, all our own, none official. Every option has a reason.

How to use

1. Work chapter by chapter at real exam pace (130 questions in 300 minutes).
2. When marking, read the reason for all four options: why the wrong ones are wrong is tested more often than why the right one is right.
3. For every miss, do its variant the same day and again three days later.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

1. Marcus, age 38, is a widowed father in Coquitlam raising two children aged 4 and 6. He earns $95,000 a year as a logistics manager, carries a $420,000 mortgage, and wants to ensure $80,000 is set aside for his children's university education if he dies prematurely. When Marcus asks an agent to calculate his life insurance need based solely on replacing his $95,000 salary, which additional financial impacts of death must the agent include to avoid underestimating the shortfall?

a. Loss of caregiver costs for childcare, debt repayment for the mortgage, and estate creation for the university fund.
b. Only debt repayment for the mortgage, because a single parent who earns a salary cannot trigger a loss of caregiver impact.
c. Only estate creation for the university fund, because the mortgage lender is legally required to forgive the loan upon a borrower's death.
d. Business impacts and Lifetime Capital Gains Exemption adjustments, because raising children is treated as a family partnership.

1′. Elena and Sam live in Nanaimo with their two-year-old daughter and Sam's disabled brother. Elena earns $110,000 annually as a pharmacist, while Sam stays home full-time to care for both dependents. They also carry a $350,000 home mortgage. If Sam dies unexpectedly, which financial impacts of death will the household face immediately?

a. No financial impact at all, because Elena's $110,000 pharmacy salary continues uninterrupted.
b. Primarily business impacts from the deemed disposition of Elena's pharmacy employment contract.
c. Loss of caregiver expenses to hire replacement care for the child and brother, alongside ongoing debt obligations.
d. Loss of primary employment income only, calculated by replacing the full amount of Elena's pharmacist salary.

2. After a health scare, 42-year-old Victor quits smoking, starts exercising daily, and installs advanced safety equipment at his workshop. He also sets aside $15,000 in a high-interest savings account to cover minor final expenses, and buys a life insurance policy to cover the $600,000 mortgage and income gap his family could not afford. How are the risk management strategies correctly classified in Victor's plan?

a. Quitting smoking is risk avoidance, the savings account is risk reduction, and the life insurance policy is risk retention.
b. Quitting smoking and safety measures are risk reduction, using savings for minor expenses is risk retention, and buying life insurance is risk transfer.
c. All three actions are forms of risk avoidance because they prevent Victor's family from suffering bankruptcy.
d. Only the life insurance policy is valid under exam rules, because risk reduction and risk retention can never be applied to the risk of death.

2′. Nadia, a wealthy retired executive in West Vancouver, has $3 million in liquid treasury bills, no debt, and no dependents. Her only financial obligation at death would be an estimated $20,000 in funeral and legal administration fees, which she decides to pay directly out of her liquid cash reserves rather than buying a new policy. Which risk management strategy is Nadia using for this $20,000 obligation, and why is it appropriate?

a. Risk avoidance, because holding $3 million in liquid cash eliminates the probability of dying.
b. Risk transfer, because leaving cash in a bank account shifts the loss to other policyholders.
c. Risk reduction, because paying funeral costs out of her own cash reserves lowers the mortality rate for her age group.
d. Risk retention, which is appropriate here because her ample liquid assets easily absorb the $20,000 financial impact.

3. Widower Raymond, age 71, owns a lakeside cottage in the Okanagan that he bought decades ago for $120,000; its current fair market value is $920,000. He plans to leave the cottage and his $400,000 RRIF directly to his adult daughter. Raymond tells his agent, 'Since Canada has no estate or inheritance tax, my estate won't owe a penny of tax when I die.' How should the agent correct Raymond's understanding?

a. Confirm that Raymond is right, because the 1972 tax reform eliminated every form of income and capital gains tax that could arise at death.
b. Explain that British Columbia charges a separate provincial inheritance tax that adult children pay directly when they inherit real estate.
c. Explain that his death triggers a deemed disposition of the cottage at fair market value, and the RRIF is fully taxable on his final return.
d. Advise that naming an adult daughter as beneficiary automatically qualifies both the cottage and the RRIF for an indefinite tax deferral.

3′. Evelyn, a divorced investor in Surrey, holds a non-registered stock portfolio purchased for $200,000 that is now worth $750,000. She intends to bequeath the portfolio to her adult nephew. What tax consequence occurs upon Evelyn's death?

a. The portfolio is deemed disposed of at its $750,000 fair market value, and the taxable part of the $550,000 gain goes on her final return.

b. No tax is triggered at death, because Canada abolished both federal and provincial inheritance taxes on estates back in 1972.

c. The entire $550,000 gain is sheltered by the Lifetime Capital Gains Exemption because publicly traded stocks always qualify.

d. Her nephew simply takes over the original $200,000 cost base and defers all of the gain tax-free, exactly as a surviving spouse would.

4. Sanjay is the sole founder of a qualified small business corporation in Abbotsford. His shares have an original cost near zero and a current fair market value of $2,400,000. Assuming he has never used his Lifetime Capital Gains Exemption (LCGE)—which is $913,630 under the 2022 exam standard ($1,275,000 in 2026)—Sanjay believes passing the shares to his adult son at death will trigger zero income tax. Under the exam rules, why does Sanjay still face a significant estate liquidity need?

a. Because the LCGE cannot be applied at death under any circumstances, so the whole $2,400,000 is taxed as if it were employment income.

b. Because the LCGE shelters only up to its limit, so the rest of the gain is taxed on the deemed disposition before the estate is distributed.

c. Because passing shares to an adult son automatically qualifies for a spousal rollover, which defers every tax until the son himself retires.

d. Because the Canada Pension Plan death benefit of $2,500 is automatically deducted from the corporation's retained earnings at death.

4′. Claire and her brother operate an ordinary commercial consulting partnership (not a family farm or fishing property, and not incorporated). Claire's partnership interest has risen in value by $800,000. She assumes the Lifetime Capital Gains Exemption ($913,630 exam standard / $1,275,000 in 2026) will completely eliminate the tax bill upon her death. Why is Claire's assumption incorrect?

a. The LCGE covers qualified small business shares and qualified farm or fishing property, not an ordinary commercial partnership interest.
b. The LCGE can only be claimed on a partnership interest if the partner dies before reaching age 65 and has no other capital gains that year.
c. Partnership interests are subject to a federal estate tax at death rather than to the deemed disposition rules for capital property.
d. Her brother, as surviving partner, can automatically claim the CPP survivor's pension and use it to pay off the partnership's tax bill.

5. Hannah, age 58, is reviewing her family's potential resources if her husband, who contributed to the Canada Pension Plan (CPP) for only eight years at low wages, were to die. She reads in the 2022 exam reference table that the maximum monthly CPP survivor's pension for a survivor under age 65 is $674.79 ($803.54 in the 2026 table) and the basic CPP death benefit is $2,500. How should the agent apply these exam figures in Hannah's needs analysis?

a. Automatically plug in the maximum $674.79 monthly pension and a $5,000 death benefit for every client regardless of contribution history.
b. Use the higher age-65-and-over maximum of $752.15 ($904.59 in 2026) because all widows are treated as seniors for CPP purposes.
c. Exclude all government benefits from the needs analysis, because CPP survivor and death benefits are only payable to residents of Quebec.
d. Know the exam table maximums, but use only the amount her husband's contribution record is actually expected to qualify for.

5′. At age 67, Walter already receives his own monthly CPP retirement pension. His wife, also 67 and a lifelong CPP contributor, passes away. Walter sees the exam-standard maximum CPP survivor's pension for age 65 and older is $752.15/month ($904.59/month in 2026) and expects to receive the full $752.15 on top of his full retirement pension, plus an automatic $5,000 death benefit with no conditions. What must the agent explain?

a. A survivor 65 or older who already draws a CPP retirement pension faces a combined cap, and the top-up to $5,000 depends on eligibility.
b. Survivors who are over age 65 are disqualified from receiving any CPP death benefit or survivor's pension once they draw their own pension.
c. Walter will automatically receive both full maximums with no reduction at all, because CPP benefits are never coordinated with each other.
d. The under-65 maximum of $674.79 ($803.54 in 2026) applies to him, because the age band is set by whether the deceased spouse was retired.

6. Compare two clients in Kamloops: Client X is a 33-year-old married mother of two toddlers with a new $550,000 mortgage; Client Y is a 68-year-old retired widower whose mortgage is paid off and whose children are self-supporting, but who still owns 100% of an active manufacturing company and wishes to leave $200,000 to a children's charity. How do their primary financial impacts of death differ across the life cycle?

a. X faces peak income, caregiver and debt impacts; Y's income loss has receded, but estate creation, business and deemed disposition remain.
b. Client X mainly needs estate creation for a charitable gift, while Client Y mainly needs income replacement for wages lost at his death.
c. Client Y has zero exposure to any of the six financial impacts of death, because he is retired, mortgage-free and his children are independent.
d. Both clients have identical risk profiles, because exposure to the financial impacts of death stays fixed throughout a person's whole life.

6′. At age 64, Patricia is retiring next month from an engineering firm in Prince George. Her group life insurance coverage through her employer will terminate upon retirement, and she only has a limited conversion window. Meanwhile, her 29-year-old son Kevin just married, bought a townhouse with a large mortgage, and welcomed his first baby. How do the Life module map and life-stage curve distinguish Patricia's and Kevin's immediate insurance priorities?

a. Patricia must calculate caregiver replacement costs for young children, while Kevin needs to exercise a group-to-individual policy conversion.
b. Patricia faces a group coverage conversion decision on a short deadline, whereas Kevin faces peak income, caregiver and mortgage debt needs.
c. Neither needs life insurance, because the probability of death is effectively zero at age 29 and becomes close to certain by age 64.
d. Kevin should buy coverage purely as an investment vehicle and skip the needs analysis, while Patricia should simply let her coverage lapse.

7. Twenty-eight-year-old Owen and his wife just had their first child in Langley. Owen tells his agent, 'According to the mortality table, my probability of death this year is tiny, so I should wait until I am in my late 50s when mortality accelerates before buying life insurance.' Based on the relationship between mortality rates, risk transfer, and needs analysis in Chapter 1, what is the flaw in Owen's reasoning?

a. Probability of death is actually highest in a person's late 20s and then declines steadily, so his risk will only fall as he gets older.
b. Waiting until his late 50s lets Owen use risk avoidance during his 30s and 40s, so no transfer of death risk is needed in those years.
c. His death risk is low, but the severity for his young family is already high, and buying young locks in coverage while premiums are lowest.
d. Life insurance should only be purchased at age 65, because that is the age at which CISRO competency component c1 starts to apply.

7′. While studying for the LLQP Life module, a candidate notices that CISRO competency component c1 ('Assess the client's needs and situation') carries the largest exam weight at 35%, yet Chapter 1 contains no complex coverage formulas. How do Chapter 1 and Chapter 10 fit together within component c1?

a. Chapter 1 sets the qualitative framework of death's impacts and risk strategies; Chapter 10 quantifies the coverage amount needed.

b. Chapter 1 carries the full 35% weight through mortality table memorization, so the Chapter 10 calculations are left unscored.

c. Chapter 1 tells agents to recommend specific policies first, and Chapter 10 then checks whether the client can afford them afterward.

d. Chapter 1 covers only group insurance conversions, while Chapter 10 covers only the provincial inheritance taxes payable at death.

Chapter 2 · Term Life Insurance Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

8. Five years ago, Elena purchased a 10–year convertible term life insurance policy. Last month, she exercised her conversion privilege to convert the policy into a permanent life insurance contract without providing proof of insurability. How do the two–year incontestability period and the two–year suicide exclusion clause apply to Elena's permanent policy?

a. Both two–year periods are measured from the issue date of the original term policy and have already been satisfied.

b. The incontestability period carries over from the original term policy, but a new two–year suicide exclusion period starts on the conversion date.

c. Both the incontestability period and the suicide exclusion clause restart for a fresh two–year window because a new permanent contract was issued.

d. The two–year periods carry over only if Elena voluntarily submits updated medical evidence at the time of conversion.

8′. One year after purchasing a 10–year convertible term life policy, Victor exercises his conversion privilege to switch to a permanent policy. How much time remains in the two–year incontestability and suicide exclusion periods under Victor's permanent contract?

a. A full two years remain, because converting within the first two policy years resets both clocks to zero.

b. No time remains, because exercising a conversion privilege automatically waives the remaining incontestability and suicide periods.

c. One year remains, because the permanent policy continues the two–year clocks from the original term policy's issue date.

d. One year remains for the suicide exclusion clause, but a full two–year incontestability period restarts upon conversion.

9. Julian is comparing two convertible term policies: Policy X uses an attained-age conversion method, while Policy Y permits an original-age (retroactive) conversion. If Julian converts five years after issue, how do the financial mechanics of Policy Y compare with Policy X?

a. Policy Y sets the ongoing permanent premium at Julian's current age at conversion and requires no lump-sum back payment at all.
b. Policy Y prices the permanent premium at Julian's younger issue age, but requires a lump-sum payment for the retroactive difference.
c. Policy Y guarantees a lower total lifetime cost than Policy X, because its initial term premiums and its conversion charges are both lower.
d. Policy Y allows Julian to convert at his original issue-age rate only if he passes a new medical examination at year five.

9′. A client holds a term policy that allows original-age conversion and asks why her friend's attained-age convertible term policy had a lower initial term premium and required no cash lump sum at the time of conversion. Which explanation accurately accounts for this difference?

a. Attained-age conversion requires the insured to pass new underwriting at the time of conversion, which lowers the insurer's overall risk.
b. Original-age conversion waives all of the ongoing permanent premiums after conversion in exchange for the one-time lump-sum payment.
c. Attained-age conversion deducts the retroactive premium shortfall directly from the term policy's accumulated cash value.
d. Original-age conversion prices the permanent plan at the younger issue age, so it costs more up front and needs a catch-up payment.

10. Arthur, age 69, owns a 10-year renewable and convertible term life policy. Under his contract, the conversion privilege expires at age 65, while the renewal privilege continues up to age 85. As his current 10-year term expires this month, Arthur's health has declined and he wants to keep coverage without medical underwriting. What option is available to him under this policy?

a. He can convert the policy to a permanent whole life contract without proof of insurability because his renewal right is still active.
b. He has lost both privileges because passing the age 65 conversion cutoff automatically cancels future term renewals.
c. He can renew the policy for another term without proof of insurability, with premiums calculated at his attained age of 69.
d. He can renew the term policy up to age 85 while paying the same premium rate he paid ten years ago.

10′. Beatrice holds a term life policy that is convertible up to age 65 but is non-renewable. Her 10-year term expires next month when she is age 60, and she recently developed a chronic condition. If she wants lifelong coverage without submitting proof of insurability, what can she do before the term expires?

a. She can exercise her conversion privilege before expiry to switch to a permanent policy without proof of insurability.
b. She cannot convert the policy because a non-renewable term contract never permits conversion without medical underwriting.
c. She can automatically renew the 10-year term for another 10 years because she is still under age 65.
d. She must wait until her chronic condition stabilizes and pass a medical exam before converting to permanent coverage.

11. Three years into a 10-year convertible term policy (convertible before age 65), Nadia informs her insurance agent that a routine physical revealed a suspicious nodule and her doctor has ordered follow-up diagnostic tests. Nadia is worried that she may become uninsurable for permanent estate coverage. How does her policy's conversion privilege apply right now?

a. She must wait until the follow-up diagnostic tests are completed and disclosed before the insurer can process a conversion.
b. The insurer can place a medical exclusion on the permanent policy for any condition under investigation on the conversion date.
c. She can exercise the conversion privilege only at the end of the 10-year term if the test results turn out to be benign.
d. She can exercise her conversion privilege immediately without proof of insurability, regardless of the pending medical tests.

11′. Gavin bought a 20-year convertible term policy five years ago. After being advised by his physician to undergo specialist testing for a newly detected symptom, Gavin asks whether he can convert his policy to permanent insurance before the test results are known. What is the legal position under his contract?

a. Converting before the specialist results are known constitutes material misrepresentation and voids the permanent policy.
b. Gavin has an unconditional contractual right to convert within the conversion window without providing any medical evidence.
c. The insurer may defer the conversion request until Gavin completes the specialist testing and receives a formal diagnosis.
d. Gavin can convert immediately, but the insurer will restart a two-year incontestability period to review his current symptom.

12. Liam and Chloe are taking out a 20-year amortizing mortgage and want life insurance to cover the declining loan balance. They compare an individual 20-year decreasing term policy with the mortgage life insurance offered by their lending institution. Which statement correctly compares these two contracts?

a. The individual decreasing term policy allows the policyholder to choose the beneficiary and keeps premiums level while the death benefit declines.
b. The individual decreasing term policy reduces its annual premium each year in exact proportion to the declining mortgage balance.
c. The lender's mortgage life insurance pays a level death benefit to the surviving spouse so any excess over the loan balance is kept by the family.
d. The lender's mortgage life insurance is fully portable and allows the borrowers to name their children as beneficiaries when switching lenders.

12′. Sophia purchases an individual 20-year decreasing term life policy to match a business loan whose principal decreases every year. Five years into the policy, she notices that her death benefit is lower than at issue, yet her annual premium notice shows the exact same amount as in year one. Why has her premium not decreased?

a. Because decreasing term policies automatically convert the premium difference into permanent cash value after year five.
b. Because the insurer priced the average risk over the whole declining 20-year schedule into one level premium for the term.
c. Because the policy is actually an increasing term rider whose rising cost offsets the savings from the declining base coverage.
d. Because premiums on a decreasing term policy only begin to drop after the first 10 years of the 20-year contract have passed.

13. Five years ago, Mei applied for and became the sole policyholder of a joint first-to-die 20-year term policy insuring both her own life and the life of her husband, Daniel, to cover their shared mortgage. After their divorce this year, Daniel wants to change the beneficiary on the policy to his new partner. What determines whether Daniel can make this change?

a. Because a divorce automatically terminates a joint first-to-die policy, neither former spouse can change the beneficiary any longer.
b. Because Daniel is one of the two lives insured under the joint policy, he automatically holds an equal right to change the beneficiary.
c. Because Mei is the sole policyholder, Daniel has no right to change the beneficiary and would need his own policy for his new partner.
d. Because a joint first-to-die policy always pays two separate death benefits, Daniel can unilaterally redirect his half of the coverage.

13′. Two business co-borrowers, Maya and Sam, are considering a joint first-to-die term life policy instead of two separate individual term policies to cover a shared commercial loan. Why does the joint first-to-die policy generally cost less than two comparable individual policies?

a. Because the insurer is exposed to paying only one death benefit, at the first death, rather than possibly paying on two policies.
b. Because a joint first-to-die policy pays out only after both Maya and Sam have died during the term, which delays the insurer's payment.
c. Because joint first-to-die policies never allow the policyholder to exercise a conversion or renewal privilege during the term.
d. Because both co-borrowers must die in the same event for the death benefit to become payable, which rarely happens in practice.

14. An agent is completing a needs analysis for a client who wants temporary coverage for two distinct needs: a 20-year income replacement period while her children are growing up, and a liability that is expected to grow with inflation over time. How do standard term insurance death benefit modalities address these needs?

a. A decreasing term policy best matches the child dependency income need, while level term is designed exclusively for amortizing mortgages.
b. Level term fits the constant dependency need; a growing need is met by increasing term or, more often in Canada, a rider or added policies.
c. Increasing term policies are the most common standalone term contracts in Canada, and they carry a decreasing annual premium over time.
d. Any temporary need lasting between 10 and 20 years must be covered by whole life insurance because term policies only exist for 1-year or 5-year periods.

14′. Before recommending a specific term length such as 10 years, 20 years, or a customized 17-year duration, what is the agent's primary step during the needs analysis stage?

a. Select a standard 20-year term first, so the client has a built-in buffer no matter when the underlying financial obligation actually ends.
b. Ask the client to choose between attained-age and original-age conversion formulas before measuring any of the liabilities involved.
c. Default to the insurer's 10-year renewable block, because all term lengths offered in Canada are fixed by insurance legislation.
d. Measure how long the client's known or estimable risk lasts, such as remaining mortgage years or years until children are independent.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

15. Nadia is reviewing a participating whole life policy proposal and asks her advisor whether the annual policy dividends shown in the current column of the illustration are legally guaranteed once the contract is signed. How should the advisor explain the legal nature of policy dividends?

a. The right to share in surplus is contractual, but whether a dividend is declared, and how much, is left to the board's discretion each year.

b. Both the right to receive a dividend every year and a minimum dividend scale interest rate are written into the policy contract as promises.

c. Dividends are locked in unless the insurer suffers an overall corporate loss, in which case policyholders must contribute to the deficit.

d. Policy dividends are identical to corporate shareholder dividends and must be paid out in any year that the insurer's stock price rises.

15′. Victor owns a participating whole life policy. This year, the insurer's board of directors announced a lower dividend scale due to softer long–term investment returns. Victor claims the insurer breached his contract because his annual dividend dropped below the initial illustration. Which statement is correct?

a. The insurer breached the contract, because the initial illustration forms part of the contractual schedule of benefits Victor signed.

b. The insurer is required to compensate Victor by raising his guaranteed cash surrender value table by an amount equal to the dividend cut.

c. There is no automatic breach, because dividend amounts are set yearly at the board's discretion, and guaranteed values remain intact.

d. Victor can demand a full refund of every premium paid since issue, because the dividend scale was changed after the contract was signed.

16. Liam, age 46, bought a $400,000 participating whole life policy ten years ago. Last year he was diagnosed with a serious chronic illness that makes him uninsurable for new coverage. He wants to use his annual policy dividends to permanently increase his death benefit and cash value without undergoing medical underwriting. Which dividend option should he use?

a. Premium reduction, which lowers his annual out-of-pocket premium and at the same time automatically increases the base face amount.

b. Paid-up additions, which use each dividend as a single premium to buy small paid-up permanent coverage with no proof of insurability.

c. Accumulate at interest, which locks in the insurer's dividend scale interest rate and later converts the balance into a permanent rider.

d. Cash payout, with the cash then used to purchase a separate paid-up term rider that attaches to the base contract without any medicals.

16′. According to the LLQP exam, which dividend option is selected on more than 90% of participating whole life policies because it permanently builds both death benefit and cash value without medical underwriting?

a. Paid-up additions (PUA)

b. Accumulate at interest

c. Premium reduction (offset)

d. Extended term insurance

17. Hannah owns a whole life policy with a $300,000 face amount and a current cash surrender value (CSV) of $80,000. Under standard exam rules where the maximum policy loan is 90% of CSV, she borrows $50,000. Two years later, when accrued loan interest reaches $6,500, Hannah dies without having repaid the loan. How much will her beneficiary receive?

a. $300,000, because policy loans are secured solely against the cash surrender value and do not reduce the death benefit.

b. $323,500, which equals the $300,000 face amount plus the remaining $23,500 net cash surrender value.

c. $243,500, which equals the $300,000 face amount minus the $50,000 unpaid loan principal and $6,500 accrued interest.

d. $250,000, because only the $50,000 loan principal is deducted from the death benefit while accrued interest is waived at death.

17′. Derek owns a whole life policy with a $250,000 death benefit and $60,000 in cash surrender value (CSV). Assuming the exam benchmark limit of 90% of CSV, what is the maximum policy loan Derek can take today, and what happens if he surrenders the policy one year later with an outstanding loan balance (principal plus interest) of $42,000 while the gross CSV is $63,000?

a. Maximum loan today is $60,000; net cash received upon surrender in one year is $63,000.

b. Maximum loan today is $54,000; net cash received upon surrender in one year is $21,000.

c. Maximum loan today is $54,000; net cash received upon surrender in one year is $208,000.

d. Maximum loan today is $225,000; net cash received upon surrender in one year is $21,000.

18. Arthur, age 58, has held a $350,000 whole life policy for 22 years and has accumulated a substantial cash surrender value. Following an early retirement, he refuses to pay any future premiums and does not want to accrue loan interest, but he insists on keeping the full $350,000 death benefit for as long as his existing policy value can support it. Which non-forfeiture option fits his objective?

a. Automatic premium loan (APL)

b. Reduced paid-up insurance

c. Cash surrender value payout

d. Extended term insurance

18′. Beatrice, age 62, owns a $400,000 whole life policy with $95,000 in cash surrender value. Her children are now financially independent, so she no longer needs the full $400,000 coverage, but she wants to stop paying premiums permanently while keeping a smaller, guaranteed lifetime death benefit for final expenses. Which option should she exercise?

a. Reduced paid-up insurance, which uses her CSV as a single premium to buy a smaller permanent policy lasting for life.

b. Extended term insurance, which maintains her full $400,000 coverage for a limited number of years.

c. Automatic premium loan (APL), which borrows against her CSV until the loan reaches 90% to 100% of the cash value.

d. Policy conversion to a Term-100 contract with no further premium obligations.

19. Fifteen years ago, Warren bought a participating whole life policy after reviewing an illustration showing that dividends and paid-up additions would offset all premiums starting in year 15. Because the insurer reduced its dividend scale interest rate several times over the past decade, the insurer notifies Warren that he must continue paying premiums for at least another seven years to keep the policy in force without loans. Which statement best explains Warren's position?

a. Premium offset is a contractual feature fixed at signing, so the insurer must waive all premiums after year 15 at its own expense.

b. Offset projections rest on non-guaranteed dividends, so a lower scale pushes back the offset point and Warren still owes premiums.

c. The policy automatically converts to a paid-up contract in year 15, but the face amount is reduced to reflect the dividend shortfall.

d. Warren can force the insurer to keep applying the dividend scale interest rate that was in effect on the date he signed the application.

19′. When presenting a participating whole life policy illustration to a prospective client today, what disclosure standard must the advisor follow to prevent the misunderstandings seen in the historical 'vanishing premium' era?

a. The illustration must show both guaranteed and non-guaranteed columns side by side, and the client must sign to acknowledge that non-guaranteed values are not promised.

b. The advisor may only show the non-guaranteed current dividend scale column as long as the dividend scale interest rate has been stable for three years.

c. The illustration must guarantee that premium offset will occur within 20 years regardless of future interest rate movements.

d. The advisor must compare the insurer's dividend scale interest rate directly against competitors' rates to prove which policy builds the highest cash value.

20. Gordon, age 54, owns a family vacation cottage that will trigger an estimated $200,000 capital gains tax liability upon his death, and he also wants to leave a fixed $100,000 bequest to a registered charity. He has ample retirement income and liquid savings, so he explicitly states that he will never need to borrow from or surrender the policy for cash during his lifetime. He simply wants the lowest level premium for guaranteed lifetime coverage of $300,000. Which policy is most suitable?

a. A 10–year renewable term policy, because renewing it every ten years avoids the permanent reserve funding cost built into lifetime plans.
b. A 20–pay participating whole life policy, because building paid–up additions gives it the lowest initial premium of the options here.
c. A Term–100 policy, because it gives lifetime coverage at a level premium below whole life by giving up cash surrender value.
d. A non–participating whole life policy, because T–100 coverage expires without any payout if the insured dies before reaching age 100.

20′. Sonia, age 42, is choosing between a non–participating whole life policy and a Term–100 (T–100) policy to cover a permanent estate need, but she also wants the flexibility to take a policy loan or opt for reduced paid–up insurance if her business cash flow tightens in her 60s. Why is T–100 unsuitable for Sonia?

a. T–100 premiums increase every year after age 60, because they are then based on yearly renewable term mortality rates.
b. T–100 usually builds no cash surrender value, so it offers no policy loan or reduced paid–up option.
c. T–100 requires the insured to pass a new medical underwriting exam every ten years to keep the coverage in force.
d. T–100 death benefits are restricted to charitable organizations and cannot be paid to any family beneficiaries.

21. Keith has held a standard Term–100 (T–100) policy for 14 years. While travelling abroad for three months, he misses his premium due date and fails to pay before the 30–day grace period expires. According to standard exam rules for a T–100 policy with no cash surrender value, what is the immediate consequence once the grace period ends?

a. The insurer automatically triggers an automatic premium loan (APL) funded from the internal policy reserve to keep the policy in force.
b. The policy converts automatically into reduced paid–up permanent insurance in proportion to the 14 years of premiums already paid.
c. The policy ends with nothing paid out, as a standard T–100 has no cash value to fall back on, though reinstatement may be sought later.
d. The insurer refunds 90% of the level cost of insurance premiums paid over the past 14 years, minus a surrender charge for early exit.

21′. Why does a traditional whole life policy have three layers of protection against accidental lapse after the 30–day grace period (APL, reduced paid–up, extended term), whereas a standard Term–100 (T–100) policy lapses outright once the grace period expires?

a. Whole life builds an accessible cash value that funds APL and non–forfeiture options; a T–100 typically has none.

b. T–100 is classified by regulators as a short–term renewable contract rather than as permanent life insurance.

c. Whole life policies have no 30–day grace period, so insurers provide non–forfeiture options as a substitute.

d. T–100 policyholders waive their statutory reinstatement rights when applying in exchange for a lower modal factor.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

22. Clara purchased a universal life policy ten years ago and chose to keep her payments at the minimally funded level while allocating her accumulating fund entirely to equity-linked index accounts. After taking a partial withdrawal last year and experiencing negative market returns this year, she receives a notice from the insurer asking for additional deposits. Why is Clara's policy now at risk of lapsing?

a. The fund must keep covering monthly insurance and admin charges; minimum funding, a withdrawal and negative returns have drained that buffer.
b. Taking a partial withdrawal automatically breaches the exemption test, so the insurer must end the coverage unless back premiums are paid.
c. Index-linked accounts carry a 0% floor, so the shortfall can only have come from the 6% modal factor applied to her monthly deposits.
d. Because the policy is minimally funded, the insurer must keep the death benefit in force to age 100 whatever happens to the account value.

22′. Victor holds a universal life policy and decides to pause his premium payments for several years while his accumulating fund is invested in mutual fund-linked accounts. During a prolonged market downturn, what combined mechanism accelerates the depletion of his policy's accumulating fund?

a. Pausing premiums immediately triggers a surrender charge equal to 5 to 10 times the annual LCOI deduction, taken from the account value.
b. The insurer automatically switches his death benefit option to level plus account value whenever a scheduled premium deposit is missed.
c. Fund losses shrink the account while the net amount at risk stays high, so insurance charges stay high and no new money comes in.
d. Provincial premium tax keeps being deducted every month from the accumulating fund, even during the years when no premiums are paid.

23. Hannah owns a universal life policy issued before 2017 that has accumulated significant cash value under maximum funded rules. In 2026, she asks her advisor to replace the life insured on the contract and substantially increase the coverage amount. Beyond medical underwriting, what major tax-related risk must the advisor investigate before making these changes?

a. Whether the changes would cost the older policy its grandfathered generation status and move it onto the stricter post-2017 test rules.

b. Whether changing the life insured will cause the insurer to retroactively apply a 6% modal factor to every deposit made since the issue date.

c. Whether going over the exemption test limit automatically cancels the death benefit while still letting the cash value stay tax-sheltered.

d. Whether the central bank's 2.25% policy rate in 2026 automatically resets the policy's adjusted cost basis to zero once the insured changes.

23′. Noah wants to deposit a large lump sum into his universal life policy to maximize tax-sheltered growth, but the insurer notifies him that the deposit would push the accumulating fund above the maximum funded threshold on the policy anniversary. Why does this statutory ceiling exist, and how is an excess handled?

a. The ceiling lets the insurer collect higher surrender charges in the first 5 to 10 years, and any excess deposit is forfeited to its reserves.

b. It stops the policy being used mainly as a tax shelter; the excess may be refused, refunded or moved to a taxable side account.

c. The ceiling protects the policyholder from negative returns in daily interest accounts, and any excess raises the face amount without underwriting.

d. The ceiling applies only to level cost of insurance, so Noah could avoid the exemption test entirely by switching his policy to YRT costing.

24. A 40-year-old female business owner applies for a $500,000 universal life policy. Under the exam's benchmark illustration, the first-year mortality charge is approximately $563 under yearly renewable term (YRT) costing—rising to about $54,521 by year 50—whereas level cost of insurance (LCOI) is fixed at approximately $3,720 per year for life. If her primary objective is permanent estate liquidity at death and predictable lifelong mortality deductions, which costing option is appropriate and why?

a. YRT costing, because the $563 initial charge guarantees lower total cumulative mortality deductions over a 50-year holding period even if she only ever pays the minimum premium.
b. LCOI costing, because it spreads the mortality cost evenly to lock in a fixed $3,720 rate for life, protecting a long-term estate plan from the steep late-life cost escalation of YRT.
c. LCOI costing initially, with a plan to exercise the standard contractual right to switch back to YRT costing after 10 to 15 years to accelerate cash value growth.
d. Either option is identical over the long run because insurers are prohibited from adjusting mortality charges even under an open-ended adjustable-rate clause.

24′. Liam needs universal life insurance mainly for a 10- to 15-year business obligation and wants as much of his early premium deposits as possible to enter the accumulating fund to build medium-term cash value, while keeping the option to lock in level rates later if his need becomes permanent. Which cost of insurance structure fits his plan?

a. YRT costing, since low early charges leave more money to grow over 10 to 15 years, and some contracts allow a later switch to LCOI.
b. Level cost of insurance, because its higher initial deductions build a faster accumulating fund balance during the first 10 to 15 years than YRT.
c. Level cost of insurance for the first 10 years, followed by a mandatory switch to YRT costing once the accumulating fund reaches $120,000.
d. YRT costing, because YRT locks in the issue-age mortality rate, so a later switch to LCOI is priced at his original age rather than attained age.

25. Two clients of the same age and health each purchase a $500,000 universal life policy and build $120,000 in their accumulating funds. Client P selected the level death benefit option, while Client Q selected the level death benefit plus account value option. How do their net amounts at risk (NAAR) and resulting monthly cost of insurance (COI) deductions compare at this point?

a. Both have a net amount at risk of $500,000 and pay identical monthly charges, because the accumulating fund belongs to the insurer until surrender.

b. P has a $500,000 net amount at risk and pays more, while Q's net amount at risk shrinks to $380,000 because the beneficiary also gets the fund.

c. P's net amount at risk falls to $380,000, lowering charges; Q's stays at $500,000, so Q pays more but would leave $620,000 at death.

d. Both have a net amount at risk of $380,000, because NAAR always subtracts the fund from the original face amount whatever option is chosen.

25′. Elena wants a universal life policy where every dollar of investment growth in her accumulating fund directly reduces the insurer's mortality exposure so that her ongoing insurance deductions stay as low as possible during her lifetime. Which death benefit option accomplishes this goal?

a. Level death benefit plus account value, because adding the account value to the payout rewards the policyholder with discounted mortality rates.

b. Level death benefit, because as the accumulating fund grows, the net amount at risk decreases dollar for dollar, lowering the basis on which cost of insurance is calculated.

c. Either option works identically, because the virtuous circle depends only on choosing a guaranteed investment account (GIA) rather than the death benefit structure.

d. Neither option reduces the net amount at risk until the policyholder reaches age 90 and the cost of insurance is fully paid up.

26. A conservative client asks her advisor how the investment accounts inside a universal life policy work and what happens if she decides to surrender the policy four years after issue. Based on the exam rules for universal life accounts and surrender rights, which explanation is accurate?

a. DIA and GIA accounts always guarantee at least the central bank's 2.25% rate, and surrendering the policy in year 4 triggers no fee at all.

b. Index–linked accounts give her direct legal ownership of fund units, and early surrender charges can exceed the fund, leaving her owing money.

c. Only LCOI policies can use guaranteed investment accounts, and surrender charges apply for the whole life of the contract until age 100.

d. DIA and GIA usually have a 0% floor and linked accounts can lose; a year–4 surrender usually brings a declining charge capped at the fund.

26′. Anxious about financial institution failures, a client asks his advisor whether the accumulating fund inside his universal life policy is protected if the life insurance company becomes insolvent, and how that topic is treated in the licensing exam manual.

a. Assuris protects policyholders' death benefits and cash values up to set limits if an insurer fails, though the exam manual never mentions it.
b. Because the accounts are unbundled, the accumulating fund is covered by bank deposit insurance rather than by an insurance industry protection plan.
c. The exam manual states that life insurers are legally immune from insolvency, so no protection organization for policyholders exists in Canada.
d. Insolvency protection applies only if the policyholder chose level cost of insurance and made no partial withdrawals in the first 5 to 10 years.

27. An entrepreneur owns a universal life policy with an accumulating fund of $120,000 and an adjusted cost basis (ACB) of $40,000. She needs $30,000 for temporary business cash flow and is comparing a direct policy loan from the insurer against assigning the policy to a bank as collateral for a $30,000 bank loan. How do these two options compare?

a. Both the policy loan and the collateral assignment are ignored for tax purposes whatever their size, and neither one reduces the beneficiary's payout.
b. A policy loan is limited to 25% of the cash value and makes the full $30,000 taxable at once, while an assignment transfers ownership to the bank.
c. The loan stays under the $40,000 ACB, so no gain arises now, but unpaid amounts cut the death benefit; the assignment usually is not a disposition.
d. A collateral assignment requires the insurer to cash out $30,000 from the fund and charge a surrender fee, while a policy loan leaves it untouched.

27′. After twenty years of funding her universal life policy, Maya has built a substantial accumulating fund and wishes to stop paying out-of-pocket premiums while keeping her insurance coverage in force without triggering a taxable withdrawal. Which contractual right allows her to do this, and what condition must hold?

a. Partial withdrawal, which lets her take out 50% to 90% of the cash value tax-free each year and send it back to the insurer as premium.
b. Premium offset, letting the account pay ongoing insurance and admin charges, as long as its value stays enough to cover them.
c. Collateral assignment, which obliges the insurer to waive all future cost of insurance deductions until the insured reaches age 100.
d. Leveraging, which permanently locks in a 0% cost of insurance charge so that the policy can never lapse whatever the investment returns.

28. A client who currently pays an annual premium into a universal life policy asks his advisor how much extra he will be charged in modal factors if he switches to monthly deposits of one-twelfth of his planned annual amount. Unlike a traditional term or whole life policy—where an exam example shows monthly payments costing roughly 6% more per year than an annual payment—how does a universal life policy treat monthly deposits?

a. Universal life applies the same 6% modal factor as term insurance, which is deducted upfront alongside provincial premium tax.
b. Universal life charges a higher modal factor of 10% to 15% unless the policyholder selects level cost of insurance (LCOI).
c. Universal life eliminates the modal factor only if the policyholder maintains a minimum balance of $40,000 in a guaranteed investment account.
d. Universal life policies do not apply a modal factor; monthly, quarterly, or semi-annual deposits annualized equal the exact same total as an annual payment.

28′. An advisor is reviewing four statements about how universal life insurance operates compared with traditional bundled permanent policies. Which statement is free from common exam misconceptions?

a. Switching from annual to quarterly deposits in a universal life policy raises the total yearly outlay, because the insurer applies a modal factor.
b. Unlike bundled whole life, UL has no modal factor, and its mortality charge is based on the net amount at risk, not the face amount alone.
c. Choosing the level death benefit plus account value option creates a virtuous circle that lowers the net amount at risk as the account grows.
d. Failing the annual exemption test automatically ends the policy's death benefit coverage on that policy anniversary, with no chance to correct it.

Chapter 5 · Riders and Supplementary Benefits Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

29. Victor and Elena each own a $50,000 life insurance policy. Victor's policy includes an accelerated dread disease (DD) benefit with a 50% advance limit ($25,000) and a 30-day survival waiting period. Elena did not add any riders to her life policy, but she owns a separate $25,000 stand-alone critical illness (CI) insurance policy. Both Victor and Elena suffer a severe stroke covered under their respective contracts, survive for more than 30 days, and each receives a $25,000 lump-sum payout. If both pass away later while their policies are in force, how much death benefit will each of their beneficiaries receive?

a. Victor's beneficiary receives $50,000, and Elena's beneficiary receives $50,000.
b. Victor's beneficiary receives $25,000, and Elena's beneficiary receives $50,000.
c. Victor's beneficiary receives $25,000, and Elena's beneficiary receives $25,000.
d. Victor's beneficiary receives $10,000, and Elena's beneficiary receives $50,000.

29′. Arthur owns a $50,000 whole life insurance policy that includes a terminal illness (TI) accelerated death benefit allowing an advance of 50% of the face amount ($25,000). After Arthur's physician certifies that his life expectancy falls within the policy's stipulated terminal period, Arthur applies for and receives the $25,000 TI benefit. When Arthur passes away later, what happens to the remaining death benefit?

a. The beneficiary receives the full $50,000 because a terminal illness benefit is paid in addition to the face amount.
b. The policy terminates immediately upon payment of the $25,000 TI benefit, leaving nothing for the beneficiary.
c. The beneficiary receives $10,000 because exercising the TI benefit incurs a 30% administrative penalty.
d. The beneficiary receives $25,000, because the $25,000 TI advance is deducted directly from the $50,000 death benefit.

30. Tariq is the sole income earner in his household, while his spouse Nadia stays home to care for their young children. Tariq applies for a $300,000 term life insurance policy on Nadia's life, naming himself as the policyholder and payor, so he could afford childcare if Nadia were to pass away. Tariq wants to make sure that if he becomes totally disabled or dies prematurely, the premiums on Nadia's policy will be waived. Which benefit must Tariq attach to Nadia's policy, and whose insurability must be underwritten for it?

a. A standard waiver of premium for total disability benefit, which requires underwriting only on Nadia as the life insured.

b. A standard waiver of premium for total disability benefit, because it automatically covers whoever pays the premiums without extra underwriting.

c. A parent/payor waiver benefit, which triggers upon Tariq's death or total disability and requires Tariq himself to undergo underwriting.

d. An accidental death rider on Tariq's own life policy, which automatically waives premiums on all family policies if Tariq is disabled.

30′. Grace purchases a permanent life insurance policy on the life of her 8-year-old daughter, Chloe, and attaches a standard waiver of premium for total disability benefit instead of a parent/payor waiver benefit. Three years later, Grace suffers a severe illness and becomes totally disabled for more than 6 months, while Chloe remains in perfect health. How will the insurer handle the premiums on Chloe's policy?

a. It will not waive them, because a standard waiver responds only to the life insured (Chloe) becoming disabled, not the payor.

b. It will waive the premiums until Chloe reaches age 21, because Grace is the legal policyholder and the person paying the premiums.

c. It will waive half of the premiums, since Grace has already satisfied the 6-month waiting period that the waiver requires.

d. It will automatically convert the standard waiver into a payor waiver retroactively once Grace submits her medical proof.

31. Liam and Maya have two children aged 8 and 10, and they attach a $10,000 family/child coverage rider to Liam's life insurance policy. Shortly afterward, Maya gives birth to twins. Tragically, one twin passes away 10 days after birth due to a congenital defect, while the surviving twin is diagnosed with a serious heart condition at age 8. Under standard exam conventions for a child coverage rider, which statement accurately describes the rider's premium, the deceased twin's claim, and the surviving twin's future conversion option?

a. One flat premium covers all the children; nothing is paid for the twin who died at 10 days; the other twin can convert up to 5 times, no medicals.

b. The premium doubles once the twins are born; the twin who died is covered from birth; and the surviving twin is barred from converting at all.

c. The premium stays flat; the claim for the twin who died is paid in full; and the surviving twin can convert up to 5 times only after full underwriting.

d. The premium rises for each child; nothing is paid for a death in the first 2 weeks; and the surviving twin can convert only on the day he turns 25.

31′. Owen adds a $10,000 child coverage rider to his whole life policy. His daughter, Zoe, develops an incurable autoimmune condition at age 8. When Zoe is 22 years old—before the rider's expiry at age 25—Owen exercises the rider's conversion privilege with an insurer that permits maximum conversion up to 5 times the rider's face amount, requesting $50,000 of permanent coverage for Zoe. How will the insurer process this conversion?

a. Decline the application because Zoe became medically uninsurable at age 8, long before the conversion request.

b. Approve only the original $10,000 without underwriting and require full medical evidence for any increase up to the $50,000 maximum.

c. Issue the $50,000 individual permanent policy without medical underwriting, charging standard rates based on Zoe's age of 22 at conversion.

d. Issue the $50,000 individual permanent policy without medical underwriting, but apply a 25% substandard health rating due to her condition.

32. At age 25, Felix purchased a life insurance policy with a guaranteed insurability benefit (GIB) rider. Five years later, on the 5th policy anniversary, Felix has developed a chronic medical condition, and he decides to exercise his GIB option to purchase additional coverage. For the purpose of the licensing exam, what triggers the right to exercise a standard GIB rider, and how will the insurer determine the premium for Felix's new coverage?

a. It is triggered any time the insured is diagnosed with an illness, and the added coverage is priced at the original age–25 rate for life.
b. It is triggered on set anniversaries such as the 5th or 10th, but Felix must pass a new medical exam because his health has since changed.
c. It is triggered on set anniversaries, and the added coverage needs no extra premium because its cost was already paid through the rider fee.
d. It is triggered on set anniversaries within the contract's limits, and the added coverage is priced at his attained age without medicals.

32′. Sonia, a young professional with a limited budget today but rising income potential, buys a life policy with a guaranteed insurability benefit (GIB). Her contract is a modern version that allows exercising the GIB either on fixed policy anniversaries or upon designated life events such as marriage or childbirth. When Sonia gets married, she wants to add coverage under her GIB without a medical exam. What procedural deadline and pricing rule must Sonia follow under this contract?

a. She can submit the application at any time within 1 year of her marriage, and the new premium is locked in at her original issue age.
b. Her advisor must apply within 31 days of the marriage, and the added coverage is priced at her attained age at that time.
c. She must wait 15 days after the marriage, and then receives the added coverage free, with no increase in her monthly premium.
d. Her advisor must submit the application within 30 days, and Sonia must pass a simplified medical questionnaire to qualify.

33. Cheng is a business owner who has a permanent estate tax liability upon death as well as a 10–year commercial loan. Instead of buying a separate whole life policy and a separate 10–year term policy, his advisor recommends buying one whole life base policy and attaching a 10–year term insurance rider to cover the loan. Why is this single–policy structure typically less expensive than two standalone policies, and what happens when the 10–year loan is paid off?

a. It is cheaper because the insurer waives underwriting on Cheng's life entirely, and after 10 years the base whole life policy expires with the rider.
b. One underwriting and one policy fee replace two; after 10 years the rider ends while the whole life base keeps covering the tax liability.
c. It is cheaper because the term rider builds cash value that offsets the loan, and after 10 years the rider continues for life at no extra cost.
d. It is cheaper because each part can be surrendered on its own, so Cheng can cancel the base policy in year 5 and keep the term rider in force.

33′. Five years ago, Brenda bought a whole life base policy to cover final expenses and attached a 10–year term insurance rider to cover a business debt. This year, Brenda decides to let the whole life base policy lapse because she finds the permanent premiums too high, assuming she can keep paying only the lower premium for the remaining 5 years of the term insurance rider. Is Brenda's assumption correct?

a. Yes, because the 10–year term rider has its own 10–year term and can stand on its own once it has been issued with the base policy.
b. Yes, provided she separately pays the $50—$100 annual policy administration fee for the rider once the base policy has lapsed.
c. No, because a term rider depends on the base policy and ends automatically if the base policy lapses or is surrendered.
d. No, unless she converts the term rider into an accidental death rider within 30 days of the lapse of the base whole life policy.

34. A comprehensive needs analysis shows that Gordon requires $1,000,000 of life insurance to support his family if he dies. To save money on premiums, Gordon proposes buying a $300,000 base term policy and adding an accidental death (AD) double indemnity rider, arguing that an unexpected death is his main concern. Two years later, Gordon dies from a sudden heart attack. Why was Gordon's planning strategy flawed, and how much will his beneficiary receive if his policy had a $300,000 base and an AD rider?

a. The family's need does not depend on the cause of death, and a heart attack is illness, not accident, so only the $300,000 base is paid.
b. The strategy was sound, because a sudden illness counts as an unexpected accident, so the beneficiary receives twice the $300,000 base.
c. The AD rider only pays if death occurs more than 1 year after an accident, so the beneficiary receives the $300,000 base benefit only.
d. A heart attack is one of the Big 4 conditions, so the AD rider automatically turns into a dread disease payout and adds an extra $50,000.

34′. Julian owns a $25,000 life insurance policy with an accidental death (AD) rider that provides double indemnity (2 times the face amount) if death results from an accident within 1 year of the event. Julian is injured in a car crash while fleeing the scene of a bank robbery he committed, and he dies from his injuries 10 days later. How much will the insurer pay under the AD rider, and why?

a. An extra $25,000, because a car crash is an accident and Julian died well within the 1–year time limit set by the rider.
b. An extra $10,000, because criminal activity reduces the double indemnity benefit by 50% instead of cancelling it outright.
c. Nothing under either the base policy or the AD rider, because dying in a car crash within 15 days voids the entire contract.
d. Nothing under the AD rider, because AD riders exclude deaths caused by criminal acts, as well as suicide and war.

35. When Simon applies for a whole life insurance policy on his own life, he wants to attach a 10–year term insurance rider covering his wife, Rachel, as well as a waiver of premium for total disability benefit. Simon assumes that because he is already undergoing medical underwriting for the base policy, Rachel will be covered automatically without underwriting, and that the waiver of premium is always included free of charge. How should the advisor correct Simon?

a. Simon is right that Rachel needs no separate underwriting, but the waiver of premium always requires an extra premium in every contract.
b. Rachel must undergo separate underwriting, while the waiver of premium is required by law to be included free in all life contracts.
c. Rachel must be underwritten herself since the rider insures her, and the quote must show whether the waiver costs extra.
d. A term insurance rider can never cover a spouse under any circumstances, so Rachel must buy her own separate whole life policy.

35′. While reviewing two life insurance quotes, Paula notices that Policy X includes a terminal illness (TI) benefit at no extra itemized fee, whereas Policy Y lists a waiver of premium benefit with a separate monthly charge. Paula asks her advisor whether all supplementary benefits are supposed to be free simply because they are called "benefits" rather than "riders". What is the correct explanation?

a. Yes, any feature called a supplementary benefit is free by law, so Policy Y is overcharging her for the waiver of premium benefit.
b. No, whether a feature is built in or charged separately depends on the contract, not its label, so each item should be broken out.
c. Yes, terminal illness benefits and premium waivers are always free, while only accidental death riders ever carry an extra cost.
d. No, built–in benefits such as Policy X's terminal illness benefit each require a separate $50—$100 annual policy fee from the client.

Chapter 6 · Group Life Insurance Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

36. Hannah is a senior analyst at an engineering firm in Vancouver, BC, earning $110,000 per year. Under her employer's group plan, senior analysts receive basic group life coverage of 2 times annual salary. The annual premium for Hannah's basic group life coverage is $1,200, paid 50% by the employer and 50% by Hannah. Which statement correctly describes the income tax treatment of the premiums and the death benefit?

a. Neither the employer's $600 nor Hannah's $600 is a taxable benefit today, but 50% of the $220,000 death benefit will be taxable if Hannah dies.

b. The employer's $600 is a taxable benefit on Hannah's T4, her own $600 is not deductible, and the $220,000 death benefit is received tax-free.

c. The employer's $600 contribution is a taxable benefit to Hannah, and she can deduct her own $600 contribution against her employment income.

d. If Hannah elected to pay 100% of the $1,200 premium herself, the death benefit would switch from taxable to tax-free.

36′. Lucas works for a software company in Kelowna, BC where the group life insurance plan requires employees to pay 100% of the basic life premiums ($540 per year for $150,000 of coverage), while the employer pays 100% of the group disability income plan premiums. How are Lucas's group life premiums and group life death benefit treated for tax purposes?

a. Lucas's $540 group life premium is tax-deductible because he pays the entire cost himself, and the $150,000 death benefit is tax-free.

b. Lucas's $540 payment creates a $540 taxable benefit on his T4, and the $150,000 death benefit is taxable because the employer funds the disability plan.

c. His $540 is neither deductible nor a taxable benefit, and the $150,000 death benefit is tax-free, just as if the employer had paid it.

d. Only half of the $150,000 death benefit is tax-free because the employer and employee split the overall benefit package costs across the two plans.

37. Tariq, age 44, is laid off from his accounting job in Burnaby, BC on October 1, which is also the date his $150,000 basic group life coverage terminates. Since developing a heart condition last year, Tariq is uninsurable on the individual market. Under the standard non-Quebec conversion rules tested on the exam, what are Tariq's rights?

a. He can convert the full $150,000 with no medical evidence if the application and first premium arrive within 31 days, priced at his current age.

b. He can automatically increase his converted coverage to $200,000 without medical evidence because $200,000 is the guaranteed minimum conversion amount in BC.

c. He only needs to notify his employer verbally within 31 days that he intends to convert, and he can keep paying his old subsidized group premium rate.

d. Because he developed a heart condition before the layoff, the insurer can require medical underwriting and decline his conversion application.

37′. Sonia, age 52, resigns from her executive role in Surrey, BC on March 15, terminating her $320,000 basic group life coverage. She has diabetes and wants to convert as much coverage as possible without providing medical evidence under the standard non-Quebec CLHIA Guideline G3 rules. What is the maximum she can convert without medical evidence, and by what deadline must she submit the application and first premium?

a. $320,000 within 60 days of March 15.

b. $400,000 within 31 days of March 15.

c. $200,000 within 31 days of March 15, with only the application form required during the 31 days and the first premium payable within 90 days.

d. $200,000 within 31 days of March 15, with both the application and the first modal premium received within that 31-day window.

38. Gavin is an architect in BC who participates in a group life insurance plan sponsored by his professional association. When a dispute arises over how his coverage schedule is defined, Gavin relies on the summary in his benefit booklet, which conflicts with the master contract held by the association. Under the contract rules and BC Insurance Act provisions explained in the lecture, what is the legal position?

a. A professional association cannot legally act as a group plan sponsor because only corporate employers can hold a group master contract.

b. The benefit booklet automatically overrides the master contract in every dispute, and Gavin is himself a signatory party to that master contract.

c. The association holds the master contract that sets the actual terms, and BC law lets Gavin obtain a copy of the group policy from the insurer on reasonable notice.

d. Outside Quebec, group members have no right to inspect or request a copy of the master policy from the insurer under any circumstances.

38′. Lin is the designated beneficiary and claimant under her late husband's group life insurance policy in BC. The insurer denies part of the claim based on a clause in the master contract that was not printed in full in the employee benefit booklet. Lin requests a copy of the relevant master policy provisions from the insurer for the first time. How does BC law treat her request?

a. As a claimant she may, on reasonable notice, inspect and copy the policy information relevant to the claim or denial, with the first copy free.
b. She has no right to obtain any part of the master contract because only the employer as policyholder can communicate with the insurer.
c. She is entitled to obtain the confidential medical records of all other employees in the group plan along with the master policy.
d. The benefit booklet is legally the only binding contract in BC, so the master policy does not exist as a separate document.

39. Owen was hired by a BC manufacturing firm on January 2, subject to a standard 3-month probationary period before group life coverage begins on April 2. On April 1, Owen is hospitalized after an accident and remains off work in the hospital through mid-April. Meanwhile, his co-worker Liam, who joined the plan two years ago, now wants to add optional additional life coverage after learning he has high blood pressure, even though the plan's 60-day initial enrolment window closed long ago. Which statement is correct?

a. Owen's coverage automatically takes effect on April 2 regardless of his hospitalization, and Liam can add optional coverage without medical evidence at any time.
b. Owen's start date turns on the contract's actively-at-work rule, and Liam must give evidence of insurability because the 60-day window has closed.
c. Owen must restart a brand-new 3-month probationary period from the day he leaves the hospital, while Liam is permanently barred from ever applying for optional coverage.
d. Group basic life insurance allows each employee to freely choose any coverage amount without limit so that adverse selection is eliminated.

39′. Why do group life insurance plans strictly limit basic coverage amounts by a schedule of benefits (such as 1x or 2x salary) and restrict non-medical optional coverage to a short initial window (such as 60 days)?

a. To control adverse selection: if members could pick high amounts or wait until their health declines, group pricing would break down.
b. To comply with the all-source maximum offset rule, which caps group life death benefits at a share of the member's pre-disability net income.
c. Because BC provincial premium tax increases from 2% to 9% whenever an employee selects coverage after 60 days.
d. Because group members are legally prohibited from owning any individual life insurance while covered under an employer group plan.

40. Victor has $200,000 of basic group life and basic AD&D coverage through his employer in BC. He also participates in the plan's dependant life coverage (which uses a flat family premium rate), voluntary family AD&D (using the exam schedule of 50% for a spouse alone, or 40% spouse / 15% per child when both spouse and children are covered), and optional survivor income benefits. Victor is married to Elena (age 41) and they have three eligible children: a 10-day-old newborn, a 16-year-old high school student, and a 22-year-old full-time university student. Which statement is correct?

a. All three children currently qualify as eligible dependants under the exam age rules, and Victor's flat-rate dependant life premium triples because he has three children.

b. The 16- and 22-year-olds qualify but the 10-day-old does not yet, Elena's AD&D is $80,000, and her survivor income runs monthly to 65, remarriage or death.

c. Elena's AD&D coverage is $100,000 (50% of $200,000), and the survivor income benefit is deducted directly from Victor's $200,000 lump-sum death benefit.

d. The 22-year-old university student is too old to qualify as a dependant, and single employees with no spouse or children are always forced to pay the same dependant life family premium.

40′. Grace has $150,000 of basic group life and voluntary family AD&D coverage under her employer's plan, which uses the exam AD&D percentages (50% for spouse only; 40% for spouse and 15% per child when both are covered). Grace has a spouse and no children. She also purchased optional survivor income benefits. If Grace dies in an illness, what happens to the survivor income benefit for her 45-year-old spouse, and what is her spouse's own AD&D coverage amount while Grace is alive?

a. Her spouse receives a monthly survivor income benefit until age 65, remarriage, or death, and the spouse's AD&D coverage amount while Grace is alive is $75,000.

b. Her spouse receives a single lump-sum survivor income payment on top of the death benefit, and the spouse's AD&D coverage amount is $60,000.

c. No survivor income benefit is payable because Grace died of an illness rather than an accident, and the spouse's AD&D coverage is $75,000.

d. Her spouse receives monthly survivor income payments for life even if the spouse remarries, and the spouse's AD&D coverage is $22,500.

41. Arthur, a quality supervisor at a BC plant with $240,000 of basic group life coverage, is planning to retire on his 65th birthday next month. Under his employer's group schedule of benefits, retirees who stay in a retiree class see their coverage reduce by 50% at age 65 and terminate completely at age 70. Arthur asks his advisor whether he can simply convert the full $240,000 on his 65th birthday without medical evidence or whether he should retire a week early solely to lock in a conversion. How should the advisor handle this situation?

a. Tell Arthur to immediately change his retirement date to one week before his 65th birthday, because every insurer in Canada prohibits conversion on or after age 65 and pension timing does not matter.

b. Guarantee that Arthur can convert the entire $240,000 without medical evidence on his 65th birthday, and tell him that group retiree coverage never terminates at age 70.

c. Tell Arthur that once group coverage reduces by 50% at age 65, the insurer pays out the reduced $120,000 portion as a tax-free cash surrender value.

d. Confirm in writing whether coverage ending on his 65th birthday still qualifies, compare retiree coverage with the $200,000 cap and its $40,000 gap, and not push early retirement.

41′. Evelyn is reviewing her employer's group life insurance schedule of benefits in BC. She currently has $220,000 of basic coverage at age 64. The schedule states that active coverage reduces by 50% on a member's 65th birthday and reduces to zero at age 70. Regarding the exam conversion rule ('before or at age 65' up to $200,000) and real-world contract verification, which statement is accurate?

a. Group life coverage for retirees must legally continue unchanged for life and can never terminate at age 70.

b. On the exam the privilege covers up to $200,000 before or at 65; in practice some insurers exclude coverage ending on the 65th birthday, so check the contract.

c. When her coverage reduces from $220,000 to $110,000 at age 65, the insurer automatically pays her $110,000 in cash as a living benefit.

d. Even if her group contract allows conversion, she can convert $220,000 without medical evidence because the $200,000 limit does not apply to members over age 60.

42. A BC logistics company decides to replace its group life insurer on July 1 and simultaneously eliminates the membership class for seasonal drivers. Mateo, a full-time warehouse worker, is currently off work on an approved disability waiver of premium under the old group policy. Meanwhile, the company controller asks about the exam cooling-off rule for group creditor insurance (CLHIA Guideline G7) versus individual life insurance (Guideline G10). Which statement is correct?

a. Mateo's disability waiver of premium is immediately cancelled when the employer switches insurers, and the seasonal drivers simply keep 50% of their old coverage under the new policy.
b. Under group creditor insurance, the borrower is the master policyholder and the death benefit is paid to the borrower's spouse rather than applied to the outstanding loan balance.
c. Mateo's waiver and coverage are not wiped out by the switch, eliminated-class members lose eligibility and must check conversion, and the exam cites a 20-day G7 refund period.
d. The exam conversion window is uniformly written as 45 days across every chapter of the manual, and replacement contracts always force healthy active employees to complete a new 3-month probationary period.

42′. Paul takes out a business loan through a lending institution in BC and enrols in the lender's group creditor life insurance plan. At the same time, his sister Rosa is on an approved disability waiver of premium under her employer's group life plan when her employer terminates the master contract. According to the lecture's rules on group creditor insurance and waiver of premium on plan termination, which statement is accurate?

a. The lender is the policyholder and the benefit equals the unpaid loan balance, and Rosa's approved waiver and coverage continue despite the termination.
b. Paul is the master policyholder of the group creditor contract, and Rosa loses her group life coverage the midnight her employer cancels the master policy.
c. Group creditor insurance death benefits remain level even as the loan is paid down, paying the excess to Paul's estate, and Guideline G7 is the 10-day individual life cooling-off rule.
d. Rosa must pay back all previously waived premiums to the insurer when her employer terminates the group plan.

Chapter 7 · Taxation of Life Insurance and Tax Planning Strategies

Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

43. Clara, a resident of Vancouver, purchased an exempt participating whole life policy in 2006 (a G2 policy). She has never taken a policy loan or cash dividend. According to the insurer's records, her cumulative premiums paid total $50,000, the cumulative net cost of pure insurance (NCPI) is $16,000, and the current cash surrender value (CSV) is $64,000. If Clara is in a 30% marginal tax bracket and fully surrenders the policy today, what is her approximate tax payable on this transaction (ignoring AMT and other credits)?

a. $9,000, because the $30,000 policy gain over her $34,000 ACB is 100% included in taxable income.
b. $4,500, because 50% of the $30,000 gain is included in taxable income as a capital gain.
c. $4,200, because her ACB is equal to the $50,000 cumulative premiums paid, resulting in a $14,000 gain.
d. $0, because proceeds from an exempt whole life policy are completely tax-free to the policyowner.

43′. Owen owns an exempt whole life policy acquired in 2008 with no prior loans or dividends. He has paid $32,000 in cumulative premiums, the insurer's cumulative NCPI is $9,000, and the current CSV is $38,000. If Owen is in a 40% marginal tax bracket and surrenders the entire policy today, what is his approximate tax liability from the surrender?

a. $2,400, using cumulative premiums of $32,000 as the ACB.
b. $3,000, applying a 50% capital gains inclusion rate to the $15,000 policy gain.
c. $6,000, based on a 100% inclusion of the $15,000 policy gain over the $23,000 ACB.
d. $7,600, applying a 50% capital gains inclusion rate to the entire $38,000 CSV.

44. Liam, a resident of Surrey, holds a G3 universal life policy with a cash surrender value (CSV) of $60,000 and an adjusted cost basis (ACB) of $14,000. He takes a $20,000 policy loan from the insurer to pay for his daughter's wedding reception. What are the tax consequences of this policy loan and the interest he pays on it?

a. No taxable policy gain arises because the $20,000 loan is less than the $60,000 CSV, and the interest is non-deductible.
b. He reports a $6,000 taxable policy gain, his ACB falls to $0, and the interest is not deductible because the money funds personal spending.
c. He must report a $6,000 taxable policy gain, and the loan interest is tax-deductible because the loan was already taxed as a disposition.
d. He must report a $3,000 taxable capital gain, his ACB remains $14,000, and the loan interest is non-deductible.

44′. Hannah owns an exempt whole life policy with a CSV of $48,000 and an ACB of $19,000. She takes a $15,000 policy loan from the insurer (not used to pay premiums on the policy) and invests the entire $15,000 in a rental condo that generates taxable rental income, with the insurer verifying the interest paid on Form T2210. What is the tax result?

a. She has no taxable policy gain, her ACB is reduced to $4,000, and the policy loan interest is deductible against her taxable income.
b. She must report a $15,000 taxable policy gain because all policy loans are fully taxable dispositions.
c. She has no taxable policy gain and her ACB stays at $19,000, because borrowing below ACB is not a disposition.
d. She has no taxable policy gain, her ACB is reduced to $4,000, but interest on a policy loan is never tax–deductible.

45. Kevin needs a $50,000 business expansion loan from a commercial lender. The lender requires him to assign his exempt whole life insurance policy (CSV $65,000; ACB $25,000) as collateral security for the loan. How does this collateral assignment affect the taxation of Kevin's life insurance policy?

a. It triggers an immediate taxable policy gain of $40,000 equal to the CSV minus the ACB.
b. It triggers a taxable policy gain of $25,000 equal to the $50,000 bank loan minus the $25,000 ACB.
c. It does not constitute a disposition of the policy, and tax–deferred growth inside the exempt policy continues.
d. It causes the policy to fail the exempt test and become a non–exempt policy subject to annual accrual taxation.

45′. Instead of using his policy as collateral for a bank loan, Kevin transfers full legal ownership of his exempt life policy (CSV $65,000; ACB $25,000) to an unrelated business partner in an arm's–length sale for $65,000 cash. How is this absolute assignment treated for tax purposes?

a. It is treated the same as a collateral assignment, resulting in no taxable disposition.
b. It is a taxable disposition generating a $40,000 policy gain, 100% of which is included in Kevin's taxable income.
c. It qualifies for an automatic tax–free rollover at the $25,000 ACB because it is transferred to a business partner.
d. It generates a $40,000 capital gain, of which $20,000 is included in Kevin's taxable income.

46. Pacific Rim Contracting Ltd., a Canadian-controlled private corporation in Vancouver, owns and is the beneficiary of a $1,000,000 G3 whole life policy on one of its shareholders to fund a buy-sell agreement. When the shareholder dies, the policy's adjusted cost basis (ACB) is $150,000. How are the death benefit receipt by the corporation and the credit to its capital dividend account (CDA) determined?

a. The corporation receives $850,000 tax-free, is taxed on the $150,000 ACB portion, and credits $850,000 to its CDA.
b. The corporation receives the full $1,000,000 tax-free and credits the entire $1,000,000 to its CDA for automatic tax-free distribution.
c. The corporation receives $1,000,000 tax-free, credits $150,000 to its CDA, and must distribute the remaining $850,000 as a taxable dividend.
d. It receives the full $1,000,000 tax-free, credits $850,000 to its CDA, and must file Form T2054 to pay a tax-free capital dividend.

46′. Cascade Engineering Inc., a private Canadian corporation, owns a $600,000 term life insurance policy on its key shareholder. Despite having no cash surrender value, the term policy still has an insurer-reported ACB of $18,000 when the shareholder dies. How much is added to Cascade Engineering's capital dividend account (CDA) from this life insurance payout?

a. $600,000, because term life insurance policies have no cash surrender value and therefore always credit 100% of the death benefit to the CDA.
b. $582,000, calculated as the $600,000 death benefit minus the $18,000 ACB reported by the insurer.
c. $291,000, because only 50% of the net insurance proceeds over ACB can enter the CDA.
d. $0, because term life policies do not qualify for the capital dividend account mechanism.

47. David and his wife Karen are both Canadian residents for tax purposes living in Burnaby. David owns a participating whole life policy with a statutory value and CSV of $70,000 and an ACB of $18,000 (with no policy loans). This year, David has a large deductible business loss from his sole proprietorship and transfers ownership of the policy to Karen for no consideration. How can David structure this transfer for tax purposes?

a. The rollover at the $18,000 ACB applies by default, but David can elect out, report a $52,000 gain against his loss, and give Karen a $70,000 ACB.
b. The transfer automatically triggers a $52,000 taxable policy gain unless David files an election to request a spousal rollover at $18,000.
c. David cannot opt out of the spousal rollover during his lifetime, so Karen must inherit the $18,000 ACB.
d. If David opts out of the rollover, only 50% of the $52,000 gain ($26,000) is reported as a taxable capital gain.

47′. Grace owns a whole life policy insuring the life of her 10–year–old son, Leo, with a CSV of $30,000 and an ACB of $12,000. She wants to transfer the policy for no consideration so that it qualifies for the tax–free intergenerational rollover to a child under ITA s.148(8). Which transfer method satisfies the rollover rule?

a. Transferring ownership of the policy to an irrevocable family trust established exclusively for Leo.
b. Transferring ownership of the policy to Leo's legal guardian to hold as trustee until Leo turns 19.
c. Selling the policy to Leo's adult sister for $30,000 fair market value consideration.
d. Transferring it for no consideration directly to Leo, or to his adult sister, who is also Grace's child.

48. An elderly resident of Maple Ridge, BC, dies leaving an ordinary life insurance policy with a $300,000 death benefit. Because the policy had no named beneficiary, the proceeds are paid into his estate, which had already exceeded $50,000 in other probatable assets. How does the lack of a named beneficiary affect the BC probate fees on the $300,000 insurance proceeds?

a. The $300,000 proceeds remain exempt from BC probate fees because all life insurance death benefits bypass probate automatically.
b. The $300,000 proceeds are included in the estate value and attract $4,200 in BC probate fees at the $14 per $1,000 rate (applicable above $50,000).
c. The $300,000 proceeds are included in the estate value and attract $1,800 in BC probate fees at the $6 per $1,000 rate.
d. The $300,000 proceeds become 100% taxable as regular income on the deceased's terminal tax return because they entered the estate.

48′. Before passing away in Maple Ridge, BC, the same senior updated his $300,000 ordinary life insurance policy to name his niece directly as the revocable beneficiary. How are the $300,000 death benefit proceeds treated at his death?

a. The $300,000 is paid outside the estate directly to his niece, avoiding BC probate fees and received tax–free as a death benefit.
b. Only an irrevocable spouse or child beneficiary bypasses probate, so naming a niece still triggers $4,200 in BC probate fees.
c. The $300,000 bypasses BC probate fees, but the niece must include 50% of the payout in her taxable income because she is not a spouse.
d. The $300,000 bypasses proportional probate fees, but the niece must pay the flat BC Supreme Court probate filing fee of $208 ($200 current) to claim the policy.

49. Martin is planning his estate and wants to know how the lifetime capital gains exemption (LCGE) applies to his business interests. Based on the LLQP exam syllabus rules and the 2022 syllabus figure, which statement accurately describes the eligibility and exam-syllabus limit for the LCGE?

a. It applies to any general commercial partnership interest up to the 2022 exam-syllabus limit of $913,630.

b. It applies to life insurance policy gains upon surrender up to the 2022 exam-syllabus limit of $913,630.

c. It applies to qualified small business corporation shares, up to the 2022 exam figure of $913,630, but not to general partnership interests.

d. It eliminates 100% of the capital gain on any Canadian corporation's shares without needing to verify asset use or holding period tests.

49′. In 2026, Fiona disposes of qualified farm and fishing partnership property and also surrenders a personal universal life policy at a gain. Under current 2026 federal tax rules described in the lecture, how do the capital gains inclusion rate, the 2026 LCGE limit, and the policy gain rule apply?

a. The farm or fishing partnership can use the $1,275,000 LCGE, the general inclusion rate is 50%, and the policy gain is fully taxable with no LCGE.

b. No partnership interest of any kind can ever qualify for the LCGE, and both the property gain and the policy gain are included at the 50% rate.

c. The 2026 LCGE limit is still $1,250,000, and the policy gain can also be sheltered by the LCGE because it is a gain on property.

d. The capital gains inclusion rate has risen to two-thirds for 2026, and the policy gain is likewise included at two-thirds.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

50. Apex Precision Ltd. relies heavily on its founder and chief metallurgist, Dr. Lin. The company carries an $800,000 commercial demand loan with a chartered bank, and the bank requires Apex to assign a $1,000,000 key person permanent life insurance policy on Dr. Lin's life as collateral. The loan interest is deductible for business purposes. Which statement correctly describes the lender's rights and the tax treatment of this arrangement?

a. The bank may call the loan under its terms and notice rules even without default, and Apex may deduct the share of the lesser of premium and NCPI that reasonably relates to the loan.

b. Because the loan is in good standing, the bank cannot call the loan upon Dr. Lin's death, and the collateral assignment triggers an immediate taxable policy disposition for Apex.

c. The bank can demand repayment immediately without any notice requirement whatsoever, and Apex can deduct 100% of the full annual permanent policy premium just because a business loan exists.

d. Apex can deduct the full net cost of pure insurance (NCPI) multiplied by the ratio of the $1,000,000 face amount divided by the $800,000 loan balance.

50′. Cedar Ridge Millwork Ltd. has a $450,000 commercial demand loan from a restricted financial institution to finance factory equipment. As a condition of the loan, the lender required the company to collaterally assign an existing $900,000 key person life insurance policy on its operations director. How does this collateral assignment affect the company's liquidity risk and tax deductions?

a. The collateral assignment converts the policy into a taxable absolute transfer, and the lender must wait until the end of the equipment's depreciation schedule before demanding repayment.

b. The company can deduct 100% of the policy's cash surrender value growth each year because the lender holds a security interest in the policy.

c. The lender may still call the loan under its terms if the director dies, and the company may deduct the part of the lesser of premium and NCPI tied to the $450,000 loan.

d. The company can deduct the entire annual premium paid on the $900,000 policy as long as the loan balance remains above zero.

51. Hannah is the sole shareholder of a Canadian-Controlled Private Corporation (CCPC) whose shares fully qualify for the lifetime capital gains exemption (LCGE). She has never used any of her LCGE before. Upon her death, the deemed disposition of her shares triggers a total capital gain of $2,200,000. Assuming a 50% capital gains inclusion rate and a 45% personal marginal tax rate, what is the resulting income tax payable on this gain using the LLQP exam figure ($913,630 LCGE)?

a. $208,125, after deducting the indexed exemption from the total capital gain and applying the 50% inclusion rate and 45% tax rate.
b. $289,433, calculated by subtracting the $913,630 exemption from the $2,200,000 gain, multiplying by the 50% inclusion rate, and applying the 45% marginal tax rate.
c. $578,867, calculated by subtracting the $913,630 exemption from the $2,200,000 gain and applying the 45% marginal tax rate directly without the 50% inclusion rate.
d. $270,000, because CCPC shares are capped at the fixed $1,000,000 agricultural and fishing property exemption limit under the rules.

51′. Three cousins are reviewing whether their respective business holdings can utilize the lifetime capital gains exemption (LCGE) upon disposition: Liam holds an interest in an ordinary retail clothing partnership; Noah holds an interest in a qualified family fishing partnership under ITA s.110.6; and Maya holds shares in a CCPC whose assets consist almost entirely of passive stock market investments. Which of them may qualify for the LCGE?

a. Noah only, since a qualified family fishing partnership can qualify, while ordinary partnerships and passive-asset CCPCs failing QSBC tests cannot.
b. Maya only, because any corporation registered as a CCPC automatically qualifies for the LCGE regardless of how its assets are invested.
c. Liam and Noah only, because all partnership interests in Canada are eligible for the LCGE while corporate shares are excluded.
d. All three cousins qualify, because the LCGE applies universally to any privately held business interest in Canada.

52. Sonia and Tariq each own 50% of the shares of Pacific Coast Logistics Inc., with each shareholder having an initial adjusted cost basis (ACB) of $50,000. The company is currently valued at $1,200,000. They are comparing a cross-purchase buy-sell agreement against a corporate share redemption agreement, both funded with life insurance. If Tariq dies when the company is still worth $1,200,000 and the buy-sell agreement is executed, how will Sonia's tax position differ between the two structures?

a. Both structures produce identical tax results for Sonia because she ends up owning 100% of the company worth $1,200,000 in either case.

b. Under the corporate share redemption structure, the total number of shares remains unchanged and Sonia receives an immediate $600,000 step-up in the ACB of her original shares.

c. Under the cross-purchase structure, Sonia uses the tax-free death benefit to personally buy Tariq's shares for $600,000, increasing her total ACB to $650,000, whereas under share redemption her ACB remains at $50,000.

d. Under the cross-purchase structure, Sonia can deduct the life insurance premiums she paid on Tariq's policy from her personal income, whereas corporate redemption premiums are taxable benefits.

52′. Two equal shareholders, Devon and Claire, funded their buy-sell agreement using the corporate share redemption method rather than a cross-purchase structure. After Devon died, the corporation received the insurance proceeds and redeemed and cancelled Devon's shares for $900,000. Five years later, Claire sells 100% of the company to an outside buyer. What is the primary disadvantage Claire now faces compared to having used a cross-purchase agreement?

a. She must repay the $900,000 life insurance death benefit to the insurer because the corporation cancelled Devon's shares.

b. She got no step-up in the ACB of her shares when Devon's shares were redeemed, so her capital gain on the later sale is larger.

c. She still only owns 50% of the voting rights in the corporation because cancelled shares remain held by Devon's estate.

d. The life insurance death benefit received by the corporation upon Devon's death was fully taxable as active business income.

53. Four equal shareholders of an engineering consultancy want to establish an insured buy–sell agreement. They want to avoid the administrative burden of managing twelve separate policies under a traditional cross–purchase plan, yet they still want the surviving shareholders to obtain a step–up in the adjusted cost basis (ACB) of the acquired shares upon a shareholder's death. Which funding structure best achieves both objectives, and how many policies are typically required?

a. A pure corporate redemption plan requiring 4 policies, because cancelling the deceased's shares automatically increases the surviving shareholders' ACB.
b. A criss–cross insurance plan owned personally by the shareholders, because 4 shareholders only require 4 policies in total when purchasing coverage on each other.
c. A split–dollar arrangement requiring 2 policies, where the deceased shareholder's estate retains the cash value and the corporation keeps the face amount.
d. A hybrid (promissory note) method with 4 corporate–owned policies, where tax–free capital dividends from the CDA let survivors pay notes used to buy the shares.

53′. A specialty bakery in Richmond was originally owned by two partners who used a cross–purchase buy–sell agreement funded by two criss–cross policies. After expanding, they admitted a third equal partner. If they continue using a personal cross–purchase structure versus switching to corporate–owned policies, how does the required number of individual policies compare?

a. Continuing with cross–purchase requires 3 policies in total, while switching to corporate ownership requires 6 policies.
b. Cross–purchase would need 6 policies, each partner insuring the other two, while corporate ownership needs only 3, one on each partner.
c. Both structures require 3 policies, because the new partner simply joins the existing two policies as a contingent beneficiary.
d. Continuing with cross–purchase requires 9 policies, while corporate ownership requires 1 individual policy covering all three lives separately.

54. Westview Holdings Inc., a Canadian private corporation, is the owner and beneficiary of a permanent life insurance policy on its founder. Upon the founder's death, the insurer pays a $1,500,000 death benefit to Westview Holdings. At the time of death, the policy has an adjusted cost basis (ACB) of $220,000. Assuming the corporation had a zero balance in its capital dividend account (CDA) prior to death, how are the receipt of the proceeds and the credit to the CDA treated for tax purposes?

a. Westview receives the entire $1,500,000 tax-free, and the full $1,500,000 is credited to its CDA for tax-free distribution to shareholders.

b. Westview receives the entire $1,500,000 tax-free, but only the $1,280,000 excess over the policy's $220,000 ACB is credited to its CDA.

c. Westview must pay corporate income tax on the $220,000 ACB portion upon receipt, while the remaining $1,280,000 enters the company tax-free.

d. Only 50% of the $1,280,000 net gain ($640,000) is credited to the CDA because corporate life insurance proceeds are subject to the capital gains inclusion rate.

54′. A corporate client tells his insurance agent: 'If my corporation buys a term life policy instead of a permanent policy to fund our buy-sell agreement, 100% of the death benefit is guaranteed to go into the capital dividend account (CDA) because term insurance has no cash surrender value (CSV).' How should the agent evaluate this statement?

a. The client is wrong; term coverage usually has no CSV but can still carry a non-zero ACB, and any actual ACB reduces the CDA credit.

b. The client is correct; because term policies never accumulate CSV, their ACB is permanently fixed at zero throughout the entire policy term.

c. The client is incorrect; proceeds from term life insurance policies are ineligible for the CDA and can only be paid out as taxable dividends.

d. The client is correct, provided the corporation deducts the annual term life premiums as an operating expense on its tax return.

55. Summit BioLabs Inc. wants to purchase key person life insurance on its chief formulator, Dr. Vance. Using the income multiple method, the agent estimates $900,000; using the profit contribution method, $1,150,000; and using the replacement and debt protection method (covering recruiter fees, dual-salary training overlap, and a personally guaranteed demand loan), $1,050,000. The CEO asks the agent whether they can simply apply for $5,000,000 of coverage since the company can easily afford the premiums. What is the correct underwriting and advisory rule?

a. The company can apply for any face amount it wishes because insurable interest in a key employee gives the corporation an unlimited right to determine coverage.
b. The agent must force the company to apply for the exact statutory mathematical average of the three methods ($1,033,333) without submitting financial statements.
c. The agent should explain what each estimate covers and apply for a financially justified amount, since underwriting will require financial proof and cut an excess.
d. The company can obtain the $5,000,000 policy only if Dr. Vance agrees to split the death benefit 50/50 with the corporation under a split-dollar arrangement.

55′. An agent is helping a construction company estimate the key person insurance amount needed for its lead project manager. The agent calculates the recruiter headhunting fee, the double-salary cost during the new hire's training period, and the outstanding balance of a commercial demand loan tied directly to the manager's personal guarantee. Which valuation approach is the agent applying, and who will own and be the beneficiary of this key person policy?

a. The profit contribution method; the project manager owns the policy and names the construction company's bank as the irrevocable beneficiary.
b. The replacement and debt protection method; the company owns the policy and is its beneficiary, so the tax-free proceeds offset these losses.
c. The income multiple method; the project manager's spouse owns the policy and receives the tax-free death benefit.
d. The split-dollar valuation method; the other employees of the construction company jointly own the policy as a cross-purchase group.

56. An engineering firm wants to provide its vice-president of operations with permanent life insurance protection as an executive benefit without bearing the entire cost of the policy. At the same time, the firm's owner is comparing the corporate small business tax rate against personal marginal tax rates for retaining earnings inside the corporation. Which statement accurately describes a split-dollar arrangement and the small business tax rate rules in BC?

a. In split-dollar, the firm and employee hold different rights in one permanent policy and split premiums by fair value; a qualifying BC CCPC pays 11% on its first $500,000 of active business income.

b. Under a split-dollar arrangement, the insurer issues two separate term policies for the price of one, and the corporation can allocate 99% of the premium to itself with no fair market value review by the CRA.

c. Because the corporate small business tax rate is lower than the owner's personal marginal rate, holding any life insurance policy inside a corporation is guaranteed to permanently save taxes in all situations regardless of subsequent withdrawal taxes or ACB.

d. The small business tax rate of 11% in BC applies to an unlimited amount of corporate passive investment income and capital gains.

56′. Horizon Tech Inc. sets up a split-dollar permanent life insurance arrangement with its chief software architect. How are the policy rights and premium payments structured under this type of arrangement?

a. The architect owns 100% of both the cash value and death benefit, while the corporation pays 100% of the premiums as a tax-free gift.

b. The corporation and the architect hold different interests in one policy, such as the face amount and the cash value, and split the premium by the fair value of each.

c. The policy death benefit is automatically credited to the employee's personal capital dividend account (CDA) upon retirement.

d. A specific section of the Income Tax Act sets a fixed 50/50 statutory premium split regardless of the age of the insured or the value of the benefits.

Chapter 9 · Application and Underwriting Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

57. Marcus, age 38, is applying for a 20-year term life insurance policy. During the application interview, he discloses that he smokes half a pack of cigarettes daily, drinks a glass of beer on weekends, works as a high school history teacher, and participates in heli-skiing in remote backcountry mountains every winter. Which of these disclosures is most likely to result in his policy being issued as a rated policy or with an exclusion clause?

a. His daily cigarette smoking, because all smokers are automatically issued rated policies above the standard rate table.

b. His regular backcountry heli-skiing, because hazardous avocations fall outside standard rate classes and lead to a rating or exclusion.

c. His weekend beer consumption, because any alcohol intake triggers an automatic moral hazard surcharge.

d. His occupation as a classroom teacher, because a person's age and occupation always trigger a separate medical rating.

57′. Four applicants are applying for standard term life insurance policies. Applicant 1 is a 45-year-old daily cigarette smoker with an office job; Applicant 2 is a 30-year-old non-smoker who drinks wine at family dinners; Applicant 3 is a 50-year-old non-smoker with a clean driving record; Applicant 4 is a 29-year-old non-smoker who accumulated four serious speeding and reckless driving convictions in the past two years. Which applicant is most likely to receive a rated policy?

a. Applicant 1, because cigarette smoking is always treated as an extra rating on top of the non-smoker table.

b. Applicant 2, because any alcohol consumption requires a rated premium.

c. Applicant 3, because being age 50 automatically places an applicant into the rated risk category.

d. Applicant 4, because multiple serious driving violations on a Motor Vehicle Record (MVR) trigger a rating.

58. Hannah completes a life insurance application for $300,000 and gives her agent a cheque for the first month's premium so she can obtain immediate coverage under a Temporary Insurance Agreement (TIA). While reviewing the separate TIA health questions, Hannah answers 'yes' to a question asking whether she has been advised to undergo diagnostic cardiac testing within the past year. What must happen regarding the TIA?

a. The TIA cannot be issued, because any 'yes' answer on the separate TIA health questions automatically disqualifies temporary coverage.
b. The TIA takes effect immediately because Hannah submitted a complete application and paid the first full month's premium by cheque.
c. The TIA takes effect for half of the applied face amount until the Attending Physician's Statement has been reviewed by head office.
d. The agent can override the health questionnaire and issue the TIA if Hannah appears healthy and energetic during the meeting.

58′. Owen, age 42, completes a formal life insurance application, answers 'no' to all questions on the Temporary Insurance Agreement (TIA) questionnaire, and offers to pay the first monthly premium. However, during the interview, the agent observes that Owen is visibly short of breath, wheezing heavily, and mentions he has been coughing up blood for two weeks without seeing a doctor. What should the agent do regarding the TIA?

a. Issue the TIA immediately because Owen answered 'no' to every formal TIA question and tendered the first monthly premium.
b. Issue the TIA but attach a respiratory exclusion clause that the agent drafts on the spot and initials with Owen.
c. Decline to issue the TIA because of the serious health concerns the agent observed, and record them for the underwriter.
d. Reject the entire formal life insurance application on the spot so the insurer never has to review Owen's file.

59. Colin applies for a $750,000 permanent life insurance policy and states on his application that he has no medical history and no hazardous hobbies. When the underwriter checks the Medical Information Bureau (MIB) database, a coded entry from a previous application two years ago indicates a cardiac abnormality. How is the underwriter permitted to use this MIB report?

a. Decline Colin's application immediately, relying solely on the coded cardiac entry that appears in his MIB report.
b. Obtain the complete medical file and the previous underwriting decision directly from the MIB database and issue a rated policy.
c. Treat the MIB code as an alert and verify through a medical exam or Attending Physician's Statement that the condition exists before deciding.
d. Ignore the MIB entry completely because privacy rules prohibit insurers from sharing information across different companies.

59′. Last year, Gavin applied for life insurance with Insurer X and was declined after a medical exam revealed severe liver disease. This month, Gavin applies for coverage with Insurer Y and omits any mention of his liver condition. When Insurer Y checks the Medical Information Bureau (MIB), what information will Insurer Y find and what must its underwriter do?

a. Insurer Y will see a coded entry for the liver condition, and its underwriter must verify that fact independently before declining or rating.
b. Insurer Y will only see that Insurer X declined Gavin, which legally bars Insurer Y from ever issuing a policy to him.
c. Insurer Y can automatically reject Gavin's application the moment the MIB code appears on screen without ordering any tests or records.
d. Insurer Y will find nothing in the MIB because medical exam findings from declined applications are deleted after six months.

60. Trevor applied for a $500,000 life insurance policy without requesting a Temporary Insurance Agreement and opted to pay the first premium upon policy delivery. Three weeks later, the insurer issues the policy at standard rates and sends it to the agent for delivery. When the agent arrives at Trevor's home, Trevor is ready to pay the first premium and sign the acceptance receipt, but mentions he was hospitalized yesterday after suffering a mild stroke. What must the agent do?

a. Collect the premium and hand over the policy because underwriting ended the moment the head office printed the contract.
b. Deliver the policy immediately because the 10-day free-look period protects the insurer against strokes occurring before delivery.
c. Deliver the policy but verbally inform Trevor that any death claim related to stroke within the first two years will be excluded.
d. Refuse to complete the delivery, withhold the policy, and contact the underwriter because Trevor's insurability has changed since the application.

60′. An insurer approves Diana's life insurance application and sends the policy contract to her agent. Under standard policy delivery requirements, which combination of conditions must all be satisfied before the agent can complete delivery and put the policy into force?

a. Diana signs the delivery receipt, the 10–day free–look period expires, and the agent files a FINTRAC large cash report.
b. Diana accepts the policy, the first premium is paid in full, and her insurability has not changed between application and delivery.
c. Diana passes a second full medical examination on the delivery date and pays a full annual premium in cash.
d. The agent verifies the named beneficiary's government ID on the delivery date and guarantees that premiums will never change.

61. Four years ago, Arthur bought a $600,000 term life insurance policy. To qualify for lower non–smoker premiums, he intentionally lied on the application and declared he was a non–smoker, even though he smoked a pack of cigarettes every day. Last month, four years after the policy took effect, Arthur died in a car accident, and the insurer discovered his long–standing smoking habit during the claim investigation. Under BC insurance law and LLQP rules, what can the insurer do?

a. Pay the full $600,000 death benefit because the two–year incontestability period has expired and bars all challenges.
b. Void the policy and deny the claim on the basis of fraudulent misrepresentation, even though more than two years have passed.
c. Adjust the death benefit downward to the amount that the non–smoker premium would have purchased on the smoker rate table, just like an age misstatement.
d. Pay the full claim because Arthur died in a car accident rather than from a smoking–related illness.

61′. Three years ago, Wendy purchased a life insurance policy and innocently omitted an early–stage benign cyst that her doctor had never mentioned to her. She also accidentally wrote her birth year as 1982 instead of 1980, making her appear two years younger. Today, while Wendy is alive and the policy has been in force for three years, the insurer discovers both unintentional errors. How are these two mistakes handled?

a. The medical omission is protected because two years in force have passed during Wendy's lifetime, while the age misstatement leads to an adjusted benefit or premium.
b. The insurer can void the entire contract immediately because any mistake on a life insurance application invalidates the coverage forever.
c. Both the medical omission and the age misstatement are completely locked in after two years, so no adjustment for her true age is allowed at all.
d. The insurer can cancel the policy for the age error but must pay a penalty for reviewing her medical file after two years.

62. Two healthy 35-year-old clients, Chloe and Derek, both want to apply for life insurance without undergoing needle blood draws or physical medical exams. Chloe applies through an accelerated underwriting program, while Derek applies for a simplified issue policy. What is the key structural difference between the two underwriting processes they have chosen?

a. Accelerated underwriting accepts every applicant automatically with no health questions at all, whereas simplified issue always requires a full Attending Physician's Statement.
b. Simplified issue offers preferred, standard, and rated risk classes at lower premiums, whereas accelerated underwriting charges one flat high rate to every applicant.
c. Accelerated underwriting still assigns preferred, standard, or rated classes using algorithms and existing data, whereas simplified issue gives a plain accept-or-decline result with no classes.
d. Accelerated underwriting is legally restricted to policies over two million dollars, whereas simplified issue is mandatory by law for all individual term policies.

62′. A client tells his agent, 'I saw an online ad for no-medical-exam life insurance. Since there is no physical exam, I am guaranteed to get the lowest standard rate even though I have a risky hobby and poor driving history.' If the product uses accelerated underwriting, how should the agent clarify the rules?

a. Confirm that skipping the medical exam means the insurer also waives all financial and moral hazard checks, so his hobby and driving record will not matter.
b. Explain that accelerated underwriting only applies after the policy has been in force for two years, so his hobby and driving record are ignored at application.
c. Tell the client that any no-medical policy is legally prohibited from charging different rates to different applicants, whatever their hobbies or driving.
d. Explain that accelerated underwriting still classifies risk using questionnaires and data such as MIB and MVR, so his hobby or driving record can still lead to a rating.

63. Five years ago, Rachel purchased a $400,000 term life insurance policy on the life of her husband, Kevin, naming herself as both policyowner and beneficiary. Last year, Rachel and Kevin finalized their divorce. Rachel continues to pay the premiums on time, and she now asks her agent whether the existing $400,000 policy is still valid and whether she can also buy a brand-new $200,000 policy on Kevin's life today. How do the rules of insurable interest apply?

a. The old policy stays valid because insurable interest is tested only at issue, but a new $200,000 policy today must meet insurable interest (or written consent) and underwriting again.
b. The existing $400,000 policy became automatically void on the day the divorce was finalized, because insurable interest must exist continuously until the insured's death.
c. Both the existing policy and the new $200,000 policy are automatically approved without any underwriting, because Rachel has already owned a policy on Kevin's life.
d. The existing policy remains valid only if Kevin signs a new Temporary Insurance Agreement every year after the divorce, and no new policy can ever be issued on his life.

63′. Six years ago, a software firm purchased a $1,000,000 key person life insurance policy on its lead architect, Martin, with the firm as policyowner and beneficiary. Last month, Martin resigned from the firm to retire completely. If the firm continues paying the premiums on the existing policy, what happens to the validity of that policy?

a. The policy terminates on Martin's last day of employment because the employer–employee insurable interest has ended.

b. The policy remains valid and in force because insurable interest existed when the contract was originally issued.

c. The policy converts automatically into a simplified issue policy owned by Martin's spouse.

d. The insurer can void the policy for moral hazard under the two-year incontestability rule.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

64. Elena, age 39, is a single mother in North Vancouver raising her 8-year-old son. Her monthly take-home pay is $4,100, and if she dies, her son's monthly living expenses are projected to be $2,600 (excluding the mortgage payment, which would be paid off in full). The son would receive a monthly CPP children's benefit of $307.81 (assuming no resulting income tax), leaving a monthly income shortfall of $2,292.19, which her agent capitalizes over 10 years using the zero net real return drawdown method at approximately $275,000. Elena owns a home with a market value of $860,000 and a remaining mortgage balance of $410,000, estimates funeral expenses at $15,000, and has $100,000 of employer-provided group life insurance available to her estate. Using the capital needs approach, how much additional life insurance does Elena need?

a. $700,000
b. $600,000
c. $425,000
d. $860,000

64′. Maya, an administrative specialist in Richmond, wants to ensure her family's expenses are covered for 14 years until her child turns 18. After deducting approved CPP survivor and child benefits of $1,111.35 per month from projected post-death monthly expenses of $4,200, her monthly income shortfall is $3,088.65, which equals approximately $519,000 over 14 years under the simplified zero net real return drawdown method (compared with $2,155,000 under the capital retention method at 1.72%). She also has one-time capital needs of $20,000 for funeral costs and $8,000 to clear credit card debt, and she holds an eligible $150,000 employer group life insurance policy. What is Maya's recommended new life insurance coverage?

a. $519,000
b. $150,000
c. $2,155,000
d. $397,000

65. Mateo, an electrical engineer in Surrey, has $84,000 of annual after-tax disposable income that his family wants to replace indefinitely using the income replacement approach. Assuming an annual investment rate of return of 5%, a marginal tax rate of 25%, and an annual inflation rate of 2%, what is the capitalized value of Mateo's income when adjusted for BOTH income taxes and inflation (keeping full rate precision in the denominator)?

a. $1,680,000
b. $2,240,000
c. $4,896,000
d. $2,856,000

65′. Hannah earns $84,000 in annual after-tax take-home pay. Her advisor is demonstrating the four-step progression of the income replacement approach using a 5% investment rate of return, a 25% marginal tax rate, and a 2% inflation rate. If the advisor accounts for the after-tax rate of return ONLY (before making any inflation adjustment), what is the resulting capitalized value?

a. $2,240,000
b. $1,680,000
c. $2,856,000
d. $4,896,000

66. After accounting for survivor benefits, a family faces a monthly income shortfall of $3,088.65. Using an after-tax, inflation-adjusted return of 1.72%, the capital retention method produces a required lump sum of approximately $2,155,000, whereas a 14-year simplified zero net real return capital drawdown calculation produces approximately $519,000. According to the LLQP framework, when is the capital drawdown method more appropriate than the capital retention method?

a. When the income need has a definite end point, such as supporting a dependent child for 14 years until adulthood or paying support for a fixed term.
b. When the primary goal is to preserve the entire insurance principal forever so that survivors live exclusively off investment interest.
c. When the agent wants a quick initial ballpark estimate during a first interview without asking about survivor expenses or duration.
d. When the surviving spouse has no other income and requires permanent, lifelong income replacement with no termination date.

66′. An agent is comparing the income replacement approach and the capital needs approach for a client couple. Why does the LLQP exam explicitly recommend the capital needs approach over the income replacement approach for making a formal coverage recommendation?

a. Because the income replacement approach requires detailed post–death household budgets and takes much longer to calculate.
b. Because the capital needs approach ignores existing insurance coverage and available assets, ensuring the client buys the maximum possible policy.
c. Because the capital needs approach itemizes actual post–death expenses, survivor income, one–time capital needs, and duration, reflecting the family's true shortfall.
d. Because the capital needs approach is legally mandated by the British Columbia Family Law Act for all married couples.

67. Gavin is divorced and remarried. Under a written mediation agreement with his former spouse, he pays $900 per month in support until his 10–year–old child reaches age 19. When Gavin's insurance agent asks about this obligation, Gavin replies, 'Our mediation agreement doesn't say a word about buying life insurance, so if I die tomorrow, that obligation disappears.' How should the agent assess this situation in British Columbia?

a. Accept Gavin's statement and omit the $900 monthly payment, because any support agreement without an insurance clause automatically terminates upon death.
b. Assume that British Columbia's Family Law Act s.170(e) automatically orders every divorced parent to purchase a brand–new permanent life insurance policy.
c. Replace the entire support obligation with the $307.81 monthly CPP children's benefit, which legally extinguishes any family law claim against the estate.
d. Review the exact wording of the mediation agreement, because if it is silent on termination at death, the former spouse may still claim against Gavin's estate under family law.

67′. Under British Columbia's Family Law Act s.170(e) and s.171, which statement accurately describes the relationship between support obligations, existing life insurance, and claims against a deceased payor's estate?

a. A mediation agreement is identical to a court order and automatically grants the former spouse the full value of the deceased's estate if insurance is not mentioned.
b. Section 170(e) can require a payor to name a spouse or child on existing insurance and keep paying premiums, and under s.171 a silent agreement may still expose the estate.
c. If a divorce agreement does not explicitly mention life insurance, the support obligation is legally void upon the payor's death in all circumstances.
d. The Family Law Act prohibits naming a former spouse or child from a prior marriage as a beneficiary once the payor remarries.

68. Nora owns shares in a Canadian-controlled private corporation (CCPC) that qualify as qualified small business corporation (QSBC) shares, while her brother Leo holds an interest in a general operating partnership (not a family farm or fishing partnership). When answering an LLQP exam question based on the 2022 exam rules regarding the tax consequences upon death, how are Nora's QSBC shares and Leo's general operating partnership interest treated?

a. Both face deemed disposition at death; under the 2022 exam rules, Nora's QSBC gain can be sheltered by the LCGE up to $913,630, but Leo's partnership interest cannot.
b. Neither is subject to deemed disposition at death because all private business interests automatically roll over tax-free to surviving siblings.
c. Leo's general operating partnership interest qualifies for the LCGE up to $913,630, whereas Nora's CCPC shares are taxed as regular employment income with no exemption.
d. Both Nora's QSBC shares and Leo's general operating partnership interest qualify for two separate $913,630 LCGE deductions upon death.

68′. Simone is the sole shareholder of a CCPC. At her death in 2026, her shares have a fair market value of $650,000 and an adjusted cost base (ACB) of $10,000. Assuming the shares meet all QSBC conditions and Simone has never used any of her Lifetime Capital Gains Exemption (LCGE), how is the $640,000 capital gain treated under 2026 tax rules?

a. The $640,000 capital gain is completely ignored and never produces a taxable capital gain or any alternative minimum tax (AMT) consideration.
b. Because CCPC shares are treated identically to a general operating partnership, the entire $320,000 taxable capital gain is fully taxable with no LCGE available.
c. Only the $10,000 adjusted cost base is subject to deemed disposition, while the $640,000 growth is taxed as a corporate dividend.
d. Half of the $640,000 gain, or $320,000, is a taxable capital gain that the capital gains deduction can offset within the 2026 LCGE of $1,275,000, subject to AMT.

69. Victor has total personal and corporate assets with a combined book and market value of $1,180,000. This total includes private corporation shares with a fair market value of $650,000 (and an adjusted cost base of $10,000) that his family intends to retain and continue operating after his death, as well as the family home in which his surviving spouse will continue living. When calculating Victor's net life insurance need under the capital needs approach, how should the $650,000 corporate shares and the family home be treated in determining 'assets available upon death'?

a. Include the full $1,180,000 total asset value as available cash, because all assets owned by the deceased automatically reduce the need for life insurance.
b. Exclude from available assets both the $650,000 shares the family will keep operating and the home in which the spouse will continue living.
c. Include the $640,000 unrealized capital gain on the corporate shares as liquid cash available to pay estate expenses.
d. Include the $650,000 corporate shares in available assets while excluding only the $10,000 adjusted cost base.

69′. During a capital needs analysis, a client lists a family cottage that she wants passed intact to her children, a retirement account that her surviving spouse will continue holding for retirement, and a high-interest savings account earmarked for debt repayment at death. Which rule governs which of these assets reduce the total capital need?

a. Exclude the cottage meant for the children and the retirement account the spouse keeps; deduct only the savings account available at death.
b. Deduct the gross market value of the cottage, the retirement account, and the savings account without adjustment for taxes or selling costs.
c. Deduct only the cottage and the retirement account, because liquid cash accounts are excluded from the capital needs approach.
d. Ignore all three assets because the capital needs approach only deducts existing life insurance policies and never deducts client assets.

70. Owen, age 46, is married and has two young children. He has contributed to the Canada Pension Plan (CPP) throughout his career. When calculating Owen's family needs for an LLQP exam question that does not specify a newer statutory year, how should the CPP death benefit and monthly CPP survivor benefits be treated?

a. Use a $5,000 CPP death benefit automatically because all married contributors qualify for the $2,500 top-up, and add the maximum monthly survivor benefits unconditionally.
b. Omit all CPP benefits from the needs analysis because government benefits are paid automatically without application and cannot offset private insurance needs.
c. Use the basic $2,500 CPP death benefit and the figures stated in the exam stem (or the 2022 exam snapshot if unspecified), without assuming every family receives the maximum monthly ceiling.
d. Substitute British Columbia's WorkSafeBC funeral benefit of $11,704.51 in place of the CPP death benefit for any illness-related death.

70′. Kendra is leaving her employer and wants to know how her group life insurance conversion privilege works when assessing her ongoing coverage needs in British Columbia. Which statement accurately explains the exam treatment and the actual regulatory rule in BC?

a. BC's Insurance Act guarantees a mandatory 90-day statutory conversion window for all group life policies, matching the pension waiver period.
b. The exam cites a 30-day or 31-day conversion window (it is internally inconsistent), while in BC conversion rests on CLHIA industry guidelines, not statute.
c. Group life insurance automatically continues at the employer's expense for 14 years after an employee resigns.
d. Converting a group life policy requires full medical underwriting within 60 days, and the exam states that conversion is prohibited before age 65.

Chapter 11 · Recommending an Insurance Policy Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

71. Elena is a single parent with a young child and a twenty–year mortgage. She is starting a new career, so her current income is limited and her long–term estate needs are still uncertain, though she expects her earnings to grow in a few years. Which life insurance recommendation best fits her situation?

a. A convertible term life insurance policy, which covers her immediate obligations at an affordable cost while preserving the option to convert to permanent coverage later without medical evidence.

b. A participating whole life policy for the full mortgage and income need, because recommending the most comprehensive permanent coverage is the safest way to avoid liability.

c. A universal life policy funded at the minimum level, because flexible premiums mean she can stop paying entirely for many years without worrying about the cost of insurance.

d. A joint last–to–die permanent policy naming her child as co–insured, since all family protection needs should be bundled into a single lifelong contract.

71′. Liam and Nora are retired spouses whose mortgage is paid off and whose children are financially independent. Their sole insurance objective is to provide cash to pay the capital gains tax on their family cottage, which will only become payable upon the death of whichever spouse dies second. They have maxed out their RRSP and TFSA room. Which policy type is most appropriate?

a. A twenty–year term policy on the older spouse alone, since term insurance has the lowest initial premium.

b. Two separate short–term policies that must be renewed every five years until the cottage is sold.

c. A joint last–to–die permanent life insurance policy, which matches the lifelong duration of the tax liability triggered upon the second spouse's death.

d. Relying solely on an employer group life policy, because group coverage has no maximum limit and always continues unchanged throughout retirement.

72. An agent in British Columbia is comparing a ten-year renewable term policy against a twenty-year term policy for a client who needs twenty years of coverage. The client also wants to name her married spouse as primary beneficiary and asks whether she will need her spouse's consent to change the beneficiary later. What should the agent tell her?

a. She should pick the ten-year term based solely on its lower first-year premium, and her spousal designation is automatically irrevocable because they are legally married.

b. She should compare cumulative premiums over the full twenty years, including the renewal jump, and in BC her spousal designation is revocable unless declared irrevocable.

c. She should name her estate instead of her spouse as beneficiary so the death benefit bypasses probate fees, and compare only the first-year monthly premiums.

d. Both policies will have identical total premiums over twenty years, and in BC only contingent beneficiaries can be changed without written consent.

72′. A policyholder in Quebec names his legally married spouse as the beneficiary of his individual life insurance policy in an application form (outside of a will) without checking either the revocable or irrevocable box. Meanwhile, his brother in British Columbia does the exact same thing on a BC policy. How do the default rules treat these two designations?

a. Quebec treats a married spouse named outside a will as irrevocable unless stated otherwise; BC treats the same designation as revocable by default.

b. Both designations are automatically irrevocable across all Canadian provinces whenever the named beneficiary is a legal spouse.

c. Both designations are revocable by default, because irrevocable status only applies when the policyholder's estate is named as beneficiary.

d. In BC the designation is irrevocable by default for married spouses, whereas in Quebec it applies only to common-law partners automatically.

73. An agent is presenting a permanent life insurance policy illustration that includes non-guaranteed cash surrender values and dividends. The client asks why there are different columns of numbers and what her signature on the illustration actually means. Which explanation by the agent is accurate?

a. Guaranteed values are shown apart from non-guaranteed projections, with at least two scenarios, and her signature confirms she understands the illustration, not any return.

b. Signing the illustration creates a binding guarantee that the insurer will credit the higher projected dividend scale for the first two policy years.

c. Only term life insurance illustrations require two dividend scenarios, whereas permanent policies only need to display a single historical return column.

d. The agent may remove the less favourable scenario column before printing if the insurer's historical participating account performance has been stable.

73′. An agent reviews a draft policy illustration for a universal life contract whose investment account returns are non-guaranteed. The printout handed to the agent displays the guaranteed column alongside only one optimistic non-guaranteed investment projection. What should the agent do before meeting the client?

a. Present the printout as is, since universal life illustrations are exempt from showing multiple scenarios.
b. Handwrite a guaranteed label over the optimistic projection so the client feels confident signing the application.
c. Use a participating whole life dividend table from another policy to serve as the second scenario for this universal life illustration.
d. Question the illustration and get a compliant version showing at least two scenarios, including a less favourable one, before presenting it.

74. An agent convinces a policyholder to surrender an existing permanent life policy with Insurer Alpha and use the cash value to purchase a new permanent policy with Insurer Beta, using misleading claims that the old policy is about to lose its coverage. To speed up the sale, the agent instructs the client to cancel the Insurer Alpha policy on the day the new application is submitted. Which statement accurately evaluates this situation?

a. The agent committed churning because two policies were involved, and cancelling the old policy upon application was proper to avoid paying duplicate premiums.
b. This is twisting through misrepresentation across insurers, and cancelling the old policy before the new one is in force and accepted breaks the replacement rules.
c. The transaction is compliant as long as the new policy offers a twenty-day rescission period, because the two-year incontestability period carries over from Insurer Alpha to Insurer Beta.
d. Misleading replacement across two companies is permissible if the client signs a Life Insurance Replacement Declaration after the old policy is terminated.

74′. Seeking to earn a new first-year commission, an agent misleads a client into withdrawing the cash value from her existing participating policy with Insurer Omega to buy a brand-new policy issued by the very same Insurer Omega, even though keeping the original contract was clearly in the client's best interest. What is the specific term for this improper practice?

a. Twisting, because any improper replacement of a permanent life insurance contract is classified as twisting.
b. Cumulative cost balancing, which is a standard step in the six-step recommendation workflow.
c. Rescission, which refers to replacing an internal policy within the same insurer for higher commission.
d. Churning, because misleading information was used to replace a policy within the same insurer.

75. At age 38, Victor bought a $250,000 twenty-year renewable term life policy at non-smoker rates for $35 per month. Now age 58, the initial twenty-year term is expiring. During the past decade, Victor started smoking and his health deteriorated, though he still needs life insurance coverage. When advising Victor on whether to renew his existing policy or apply for a new policy, what is the critical mechanism the agent must explain?

a. Applying for a new policy is always cheaper than renewing an expiring term contract, regardless of whether the insured has started smoking in the meantime.
b. Renewing the existing policy will trigger a new two-year incontestability period and require Victor to pass a full medical exam at smoker rates.
c. Renewal pricing follows his original health class from issue, while a new policy requires underwriting as a smoker and must be compared with the contract's renewal rates.
d. Victor must cancel his expiring policy before submitting a new application so that the insurer does not reject him for over-insurance.

75′. Hannah, age 45, owns a $300,000 participating whole life policy purchased five years ago that has accumulated $18,000 in cash value. An agent suggests she surrender this policy to buy a new universal life policy with a critical illness rider. Which item MUST be included in the written pros-and-cons comparison (reason-why record) before Hannah decides?

a. A statement that the five years already served under the old policy's incontestability period will transfer to the new universal life contract.
b. Disclosure that the two-year incontestability period restarts, cash value builds again from zero, and the new coverage and rider face current underwriting.
c. A comparison using the participating whole life account's historical dividend rates to project the guaranteed return of the new universal life policy.
d. An assurance that because the new policy adds a critical illness rider, replacement disclosure forms are not required.

76. A client in British Columbia tells her agent that she wants to replace her existing individual life insurance policy with a new individual life contract, adding that because replacing the policy was her own idea, they can skip the paperwork. Under the exam standard, which statement correctly describes the replacement disclosure requirement across Canada?

a. Replacement disclosure is waived whenever the policyholder initiates the replacement without solicitation from the agent.
b. Only the policy applicant needs to sign the replacement declaration, even when the life insured under the contract is a different person.
c. Disclosure is still required whoever initiated it, and the exam says most jurisdictions use the LIRD, while Quebec uses its own replacement notice.
d. The LIRD form is used exclusively in Quebec, while British Columbia and all other provinces have no written replacement declaration form.

76′. An agent in British Columbia is handling a life insurance replacement where the policy applicant is a business owner and the life insured is a key employee. Before proceeding with the new replacement application, what documentation and signatures must the agent obtain?

a. Explain the declaration, have both the applicant and the life insured sign it, and attach a written note on the reasons, benefits, and cases where the new policy may not pay.

b. Only a verbal confirmation from the business owner is required before application, provided the written LIRD is mailed within thirty–one days after the old policy lapses.

c. Only the key employee needs to sign the LIRD form, and no written comparison is needed if the new policy has a higher face amount.

d. No replacement declaration is required in British Columbia because replacement disclosure is solely an informal industry custom in Quebec.

77. After completing a needs analysis showing a total insurance gap of $600,000, an agent recommends a combination of term and permanent policies. The client states that he only wants to purchase $300,000 of term insurance right now and declines the rest. Which action should the agent take to properly conclude this recommendation?

a. Repeatedly pressure the client until he agrees to the full $600,000 package, because an agent must never process a partial coverage application.

b. Process the $300,000 application and discard all notes about the $600,000 recommendation so the file shows no discrepancy.

c. Tell the client that reason–why records are only written when an existing policy is being replaced, so no written note is needed for a new application.

d. Explain the risks left uncovered, record the $600,000 recommendation, the alternatives, and his $300,000 choice in a reason–why record, and ask him to acknowledge the gap.

77′. An agent is writing a reason–why record for a client who considered a pure term insurance option but ultimately chose a combination of term insurance and a small participating whole life policy to build cash value for retirement. Besides the summary of the client's situation and the final recommendation matched to specific needs, what other elements belong in a sound reason–why record?

a. Only the agent's commission schedule and a verbatim copy of every page of the insurer's policy contract.

b. The alternative options considered and why they were not chosen, along with the client's response (acceptance, partial acceptance, or refusal after having the risks explained).

c. A guarantee signed by the agent promising that the participating policy's non–guaranteed dividends will never decrease.

d. A Quebec replacement notice, because every new recommendation across Canada requires a replacement declaration even when the client owns no prior insurance.

Chapter 12 · Ongoing Policy Service Life Insurance

Items marked ′ are variants on the same point: do one when you miss the main question.

78. Liam owns an individual life insurance policy and contacts his agent to request several changes over the course of the year. Which of the following policy changes requires Liam to provide evidence of insurability for underwriting approval?

a. Changing his rate classification from smoker to non-smoker after quitting tobacco
b. Completing a collateral assignment of the policy to secure a bank loan
c. Reducing the face amount of coverage to lower his monthly premium
d. Changing the revocable beneficiary designation from his brother to his sister by written declaration

78′. Nora owns a permanent life insurance policy and wants to transfer all ownership rights permanently to her adult daughter, while also removing an accidental death rider she no longer needs. How does the insurer treat these two requests with respect to underwriting and taxation?

a. Both the ownership transfer and removing the rider require medical underwriting
b. Removing the rider triggers a taxable disposition, while the ownership transfer has no tax impact
c. Neither request requires underwriting, but the absolute assignment is generally a disposition that triggers a tax review
d. The absolute assignment is excluded from disposition rules under s.148 just like a collateral loan assignment

79. Marcus missed a renewal premium on his individual term life policy. After the 30-day grace period ended without payment and the policy lapsed, Marcus waited another 55 days before contacting his insurer to reinstate the policy. Under BC Insurance Act s.57, what is required for Marcus to reinstate his policy at this point?

a. He only needs to pay the overdue premium because he is still within the 2-year reinstatement period
b. He must apply within the 2-year window, pay all overdue premiums and contract indebtedness with permitted interest, and provide satisfactory evidence of health and insurability
c. His policy remains automatically in force because the 30-day grace period and 30-day short reinstatement window combine into 60 days of continuous coverage
d. He has permanently lost the statutory right to reinstate because more than 30 days have passed since the end of the grace period

79′. Elena missed a renewal premium on her individual life policy. During the 30-day window after the 30-day grace period expired and the policy lapsed, Elena died in an accident before paying the overdue premium. The next day, her spouse tendered the overdue premium to the insurer claiming the policy was within the 30-day post-grace reinstatement window. How will the insurer respond under BC Insurance Act s.50 and s.57?

a. Deny the claim and refuse reinstatement because the policy had lapsed and the life insured was no longer alive when payment was tendered
b. Pay the full death benefit minus the overdue premium because death occurred within 30 days after the grace period ended
c. Reinstate the policy if the spouse can prove Elena was in good health on the day before the accident
d. Pay a reduced death benefit proportional to the premiums paid before the lapse

80. Victor designated his adult daughter, who is 19 years old, as the irrevocable beneficiary on his individual life insurance policy and properly filed the designation at the insurer's head office in Canada while alive. Two years later, Victor wants to borrow against the policy's cash value or change the beneficiary to his new partner. Under BC Insurance Act s.60 and s.66, what rule applies?

a. Victor can change the beneficiary on his own at any time simply by signing a new will that names his partner
b. Victor can take a policy loan without consent, and only needs his daughter's consent if he surrenders the policy completely
c. While his daughter lives, he cannot alter the designation or deal with the policy without her consent, save statutory or court exceptions
d. The designation is automatically treated as revocable because BC does not recognize irrevocable beneficiaries outside Quebec

80′. Hannah executes a valid will in which she states that her brother is to be the irrevocable beneficiary of her life insurance policy. She never sends a copy of this designation to the insurer's head office in Canada during her lifetime. Under BC Insurance Act s.60, what is the legal effect of making an irrevocable beneficiary designation in a will?

a. It becomes fully binding as an irrevocable designation once the will is probated and filed with the insurer after her death
b. A will cannot create an irrevocable designation, so the wording takes effect only as a revocable declaration
c. It invalidates the entire life insurance policy, and the insurer must refund all premiums paid to her estate
d. It causes the death benefit to be forfeited to the insurer because the designation was never filed with it

81. David bought a life insurance policy in BC and named his wife, Clara, as the revocable beneficiary in the policy contract. Five years later, David and Clara divorced, and David remarried. David never submitted a written declaration to change the beneficiary on his policy before he passed away. How does the divorce affect Clara's status as the policy beneficiary in BC?

a. Divorce automatically revokes a former spouse's designation on any life insurance policy in every Canadian province, including BC
b. Divorce does not revoke the policy designation, so Clara stays the beneficiary on record unless a valid written declaration changes it
c. The death benefit is automatically redirected to David's new spouse as soon as the remarriage is registered
d. The policy lapses automatically on the date the divorce judgment takes effect

81′. After finalizing his divorce, Owen called his life insurance agent and verbally instructed the agent to remove his ex-spouse and name his sister as the revocable beneficiary. Owen died shortly afterward without ever signing a written declaration, and the insurer paid the death benefit to the ex-spouse listed on its records. Under BC Insurance Act s.59 and s.77, is the insurer liable to pay Owen's sister a second time?

a. Yes, because a verbal instruction given to a licensed agent is legally equivalent to a signed declaration filed with the insurer
b. Yes, because the insurer must investigate the insured's family changes before it pays any former spouse on record
c. No, only half of the benefit must be paid to the sister because the agent made a verbal promise
d. No, because a change needs a written declaration, and the insurer is discharged when it pays per its records before written notice arrives

82. An agent convinces a client to cancel an existing permanent life policy with Insurer X and purchase a new policy with Insurer Y using misleading comparisons that hide the surrender charges and new contestability period. When replacing a life policy in BC, how is this improper cross-company practice termed, and what mandatory step applies to any legitimate replacement?

a. Churning; the agent must cancel the old policy with Insurer X first, and only then submit the new application to Insurer Y
b. Twisting; give and explain the replacement declaration and pros-and-cons statement before applying, and keep the old policy until the new one is in force
c. Twisting; the replacement declaration and the written pros-and-cons statement are only required after the new policy has been delivered
d. Churning; in addition, exercising a contractual group conversion option is always treated as a statutory replacement under the regulation

82′. When a policy passes the 2-year incontestability period after issue, later lapses due to non-payment, and is subsequently reinstated under s.57, what happens to the suicide exclusion period and disclosure rules upon reinstatement?

a. Disclosure rules reapply, and the contract's suicide exclusion period (commonly 2 years) restarts from the latest reinstatement date
b. Neither the incontestability period nor the suicide clause restarts because the original 2-year period was already completed
c. Only the suicide clause restarts, and it lasts just 30 days, while the incontestability period never restarts after reinstatement
d. The insurer can contest any non-fraudulent misstatement at any time for the rest of the policy's life once it has been reinstated

83. Arthur passed away five years after buying an individual life policy with a $120,000 face amount. During claim verification, the insurer discovered an unintentional recording error on the application that understated Arthur's age by three years: he paid $240 per year, whereas the correct premium for his true age was $300 per year. Under BC Insurance Act s.54, how much death benefit is payable?

a. $0, because the misstatement of age voids the contract even after 2 years
b. $120,000, because the 2-year incontestability period has expired and prevents any adjustment
c. $96,000, calculated as $120,000 multiplied by ($240 divided by $300)
d. $150,000, calculated as $120,000 multiplied by ($300 divided by $240)

83′. Suppose instead that on a $120,000 individual life policy, an unintentional recording error overstated the insured's age by three years: the insured actually paid $300 per year, whereas the correct premium for the true younger age was only $240 per year. Under BC Insurance Act s.54, what happens when the claim is settled?

a. The death benefit remains capped at $120,000 because s.54 only permits downward adjustments
b. The benefit rises to $150,000, calculated as $120,000 multiplied by ($300 divided by $240)
c. The death benefit is reduced to $96,000 regardless of the direction of the error
d. The insurer voids the policy and refunds $300 per year to the estate

84. A life insured goes missing after a boating trip and no body is recovered. For the purpose of the LLQP exam, after how many years of unexplained absence can the beneficiary generally apply to a court for a declaration of presumption of death?

a. 2 years
b. 5 years
c. 6 years
d. 7 years

84′. A husband (the policyowner and life insured) and his wife (the sole primary beneficiary) die together in a car crash in BC, and it cannot be determined who died first; the policy has no contingent beneficiary or contrary declaration. Meanwhile, two distant relatives file competing claims with the insurer demanding the proceeds. Under BC Insurance Act s.82 and s.83, which rules apply?

a. The life insured is presumed to have died first so the proceeds pass to the wife's estate, and the insurer must adjudicate the relatives' dispute itself
b. The wife is presumed to have died first, so proceeds are paid as if she did not survive him; the insurer may pay into court amid competing claims
c. The insurer must wait 7 years before paying anyone, because the order of the two deaths can never be determined
d. The proceeds are split equally between the two estates, and the insurer is not allowed to pay the money into court

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

Accident & Sickness

Items marked ′ are variants on the same point: do one when you miss the main question.

85. Arthur and Beatrice, a married couple approaching age 65, are reviewing their financial plan with their advisor. They have accumulated a retirement portfolio designed to support their expected retirement years, but longevity runs in both of their families and Beatrice's elderly mother is currently living in a private care facility. If Arthur and Beatrice live much longer than expected and exhaust their savings while requiring ongoing assistance with daily living, which risk category and primary financial goal are directly threatened?

a. Mortality risk threatening their family's short-term mortgage payments.
b. Longevity risk, which threatens their retirement income and accumulated wealth as their assets run out.
c. Systematic market risk threatening their business overhead expenses.
d. Short-term disability risk threatening the employment paycheques they still earn before retirement.

85′. Evelyn, an adult under age 65, tells her insurance advisor that she is only worried about dying too soon or becoming disabled before age 65. She believes that living a very long life past her life expectancy is purely a blessing and poses no financial risk to her retirement plan or the estate she hopes to leave her children. How should the advisor correct Evelyn's understanding?

a. Agree with Evelyn, because A&S needs analysis only evaluates risks that occur before age 65.
b. Explain that living longer raises her mortality risk, which she should handle by buying additional accidental death coverage.
c. Explain that longevity is a real financial risk: outliving savings or needing long-term care can drain retirement income and erode her estate.
d. Advise her that federal Employment Insurance sickness benefits will cover her living expenses if her retirement savings run out in old age.

86. Logan owns a custom cabinetry manufacturing company with salaried employees. Over the past year, he has become concerned about two potential threats: (1) a province-wide housing market slowdown and rising interest rates that could sharply reduce customer orders, and (2) the possibility that he suffers a severe stroke, leaving the business unable to pay its monthly factory lease and staff wages while he recovers. How are these two threats classified in an A&S business needs analysis?

a. Threat (1) is systematic risk that A&S products cannot insure; Threat (2) is unsystematic, business-specific risk that A&S business cover or self-funding can address.
b. Both threats are systematic risks, and a Business Overhead Expense (BOE) policy will reimburse lost revenue from both economic downturns and the owner's stroke.
c. Threat (1) is unsystematic risk covered by key person disability insurance, while Threat (2) is systematic risk covered by Workers' Compensation.
d. Neither threat can be transferred to an A&S insurer, because business fixed expenses must always be handled 100% through risk retention.

86′. Nadia runs a boutique engineering consultancy. She asks her advisor whether she can buy an Accident and Sickness policy that will pay her firm's office rent if a new competitor enters her city and undercuts her pricing, or if she is hospitalized for four months due to a serious car accident. Which statement accurately explains what A&S insurance can cover?

a. A&S insurance can cover office rent during the price war, because a new competitor's pricing counts as an unsystematic health risk.
b. A&S can cover eligible fixed expenses if Nadia is disabled by the accident (unsystematic risk), but not losses from market competition (systematic risk).
c. Federal Employment Insurance will pay the consultancy's commercial office lease directly in both scenarios, so no A&S policy is needed.
d. Both scenarios must be managed exclusively through risk avoidance by closing the consultancy immediately.

87. Kevin is a salaried warehouse supervisor who suffers a non-work-related knee injury requiring surgery and recovery. He has no employer short-term disability plan, so he relies on federal Employment Insurance (EI) sickness benefits before his individual disability policy takes over. Based on the Harmonized LLQP exam baseline, what is the maximum duration and income replacement percentage of EI sickness benefits after the one-week waiting period?

a. Up to 15 weeks at 55% of insurable earnings (up to the maximum weekly benefit).
b. Up to 15 weeks at 90% of net income, coordinated through the provincial workers' compensation board.
c. Up to 52 weeks at 75% of gross pre-disability salary with no waiting period.
d. Indefinitely until age 65, provided the knee injury is severe and prolonged.

87′. An advisor is preparing for the LLQP exam while also updating her BC practice checklists for 2026. She is comparing the federal Employment Insurance (EI) sickness benefit rules in the LLQP exam manual against current federal legislation (effective since December 2022). Which pairing correctly states the maximum benefit duration under the exam baseline versus the current 2026 rule?

a. Exam baseline: 26 weeks (55% replacement); Current 2026 rule: 15 weeks.
b. Exam baseline: 16 weeks (about four months); Current 2026 rule: 52 weeks.
c. Exam baseline: 15 weeks; Current 2026 rule: 26 weeks (55% replacement in both).
d. Exam baseline: 12 months of benefits; Current 2026 rule: 24 months.

88. Mateo is a salaried electrician in British Columbia who is severely injured when scaffolding collapses at his job site. He is unable to work for several months. Mateo has provincial workers' compensation coverage (WorkSafeBC) and an employer group disability plan. When Mateo asks if he can collect full workers' compensation benefits, full federal EI sickness benefits, and full group disability benefits on top of each other to earn more than his regular pay, how should his advisor explain the coordination of benefits?

a. He can stack all three benefits in full without any reduction, because government programs and group plans never coordinate with each other.
b. Federal EI sickness benefits always pay first for workplace injuries, and Workers' Compensation only begins paying after EI benefits run out.
c. Workers' Compensation pays first for a work injury (about 80—90% of net earnings; about 90% in BC), and the group plan only fills gaps after offsets and caps.
d. The provincial Medical Services Plan (MSP) will replace about 90% of his lost wages for the months he is unable to work.

88′. Hannah suffers a non-work-related autoimmune illness that leaves her permanently unable to work. She qualifies for the CPP disability benefit (CPP-D) after four months and also holds an employer group long-term disability (LTD) policy and a personally paid individual disability policy. When estimating Hannah's net monthly cash flow, what is the advisor's correct approach?

a. Check each contract's offset clauses and all-source maximum, since CPP-D is usually integrated with and deducted from group LTD rather than added on top.
b. Add the maximum CPP-D benefit, the full group LTD benefit and the full individual DI benefit together as guaranteed tax-free monthly income.
c. Instruct Hannah to file a claim with WorkSafeBC first, because WorkSafeBC is the first payor for all severe illnesses regardless of cause.
d. Advise Hannah not to apply for CPP-D so that she never has to read her group policy's coordination rules.

89. During a fact-find interview, Priya tells her advisor that she has two distinct concerns: first, she does not want routine prescription drugs, physiotherapy, and dental bills (which are not covered by her provincial health plan) to drain her monthly bank savings; second, she does not want to be forced to liquidate her investment portfolio or family home if she suffers a major heart attack or needs years of nursing care later in life. Under the four A&S need categories, how are Priya's two concerns matched to insurance products?

a. First concern: 'protecting assets' with critical illness insurance; second concern: 'protecting savings' with extended health and travel cover.
b. Both concerns fall under 'protecting income' and should be solved with one disability income (DI) policy alone.
c. First concern: 'protecting business' with a BOE policy; second concern: 'protecting income' with an AD&D policy.
d. First concern: 'protecting savings' with extended health and dental; second: 'protecting assets' with critical illness and long-term care insurance.

89′. Liam has built a substantial investment estate that he wants to pass on to his children intact. He is already retired, so he has no employment income to replace, and he has a retiree group plan that reimburses routine prescription drugs and dental cleanings. However, he worries that requiring long-term private facility care for cognitive decline would force his family to sell his investment properties. Which A&S need category and product directly address Liam's remaining gap?

a. Protecting income, addressed by purchasing an own-occupation disability income policy.
b. Protecting assets, through long-term care (LTC) insurance that helps avoid a forced sale of his estate.
c. Protecting savings, by purchasing a second travel and dental insurance policy on top of his retiree plan.
d. Protecting business, addressed by a key person disability insurance policy.

90. An advisor is explaining to a surgical specialist why different disability income policies have different premium rates and claim thresholds. The advisor refers to the four-level spectrum of disability definitions used across the LLQP exam. Ranked from the MOST liberal (easiest for the claimant to qualify for benefits) to the MOST restrictive (hardest to qualify), what is the correct order of this spectrum?

a. CPP total disability → any occupation → regular occupation → own occupation.
b. Own occupation → regular occupation → any occupation → CPP total disability.
c. Regular occupation → own occupation → CPP total disability → any occupation.
d. Any occupation → regular occupation → own occupation → CPP total disability.

90′. Dr. Lin is an orthopedic surgeon whose hands are injured in an accident. She can no longer perform surgery, but she is medically able to work full-time as a university medical lecturer or hospital administrator. Under which disability definition on the four-level spectrum would Dr. Lin have the LOWEST threshold (greatest likelihood) to qualify for disability benefits despite her ability to teach?

a. CPP total disability (severe and prolonged).
b. Any occupation definition.
c. Extended health care reimbursement definition.
d. Own occupation definition.

91. Victor owns a thriving dental clinic with ongoing monthly fixed overhead expenses (staff salaries, equipment leases, and commercial rent) and also has ongoing monthly family living expenses at home. He tells his advisor that he plans to buy a single personal Critical Illness (CI) policy and skip Business Overhead Expense (BOE) insurance, reasoning that a CI lump sum has no spending restrictions and can easily cover both his clinic and his family if anything happens to his health. What is the primary flaw in Victor's plan?

a. Personal CI lump-sum benefits are legally prohibited from being spent on commercial rent or employee wages under BC law.
b. Government Employment Insurance will automatically pay the clinic's monthly overhead while he is sick, so both CI and BOE are redundant.
c. It mixes family and clinic needs: a disabling condition may not meet a CI definition, and one lump sum may not cover both recovery and ongoing overhead.
d. BOE policies pay a guaranteed lump sum when a critical illness is diagnosed, even if the business has no fixed expenses at all.

91′. Camille owns a small bakery in Richmond. She recently suffered a covered critical illness and received a lump-sum payout from her personal Critical Illness (CI) policy. Because the policy has no restriction on how she uses the money, she is using it to pay the bakery's rent and bakers' wages while also paying her household mortgage and medical recovery costs. When reviewing this case as a lesson for other small business owners, how should an advisor compare personal CI with Business Overhead Expense (BOE) insurance?

a. Unrestricted CI money can pay business bills, but household and business needs should be assessed separately, since BOE reimburses eligible overhead monthly up to set limits.
b. Tell business owners that under provincial insurance law, using personal CI benefits to pay staff wages voids the policy retroactively from the date of claim.
c. Recommend replacing all personal DI and CI policies with BOE, because BOE also covers the owner's personal mortgage payments and family groceries.
d. Advise that corporate-owned CI policies never require checking who owns the policy or who is named as the beneficiary.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

92. Dr. Marcus, an orthopedic surgeon, is covered by both an individual disability insurance policy with an own occupation definition and a hospital group long-term disability plan that also uses an own occupation definition. After a hand tremor permanently prevents him from performing surgery, he takes a full-time medical school teaching position earning $95,000 a year. Ignoring any all-source maximum offset, how do the two policies treat his disability benefits while he teaches?

a. The individual policy keeps paying in full, while the group benefit is reduced or stopped because group own occupation works like regular occupation.
b. Both policies continue paying full unreduced benefits because both contracts specify an own occupation definition.
c. Both policies terminate benefits immediately because his teaching role matches his medical education, training, and experience.
d. The group policy keeps paying full benefits, while the individual policy stops paying as soon as he earns any employment income at all.

92′. Clara, a commercial airline pilot, loses her medical flight certification due to a permanent inner-ear disorder. She has a group long-term disability policy with an own occupation definition. Two months into her claim, the airline offers her a full-time ground-based flight simulator instructor position that matches her background, and she accepts it. Under the exam rules for group own occupation definitions, what happens to her group disability benefit?

a. She continues to receive her full group disability benefit on top of her instructor salary because she can no longer fly commercial aircraft.
b. Her group benefit is automatically converted into an individual non-cancellable policy with no reduction in payout.
c. Her group benefit is reduced or stopped, because a group own occupation clause works like regular occupation once she accepts other work.
d. Her group disability benefit is doubled for 6 months as a standard statutory rehabilitation bonus.

93. Liam is a self-employed graphic designer applying for an individual disability income policy. His tax return shows $140,000 in gross business revenue, $50,000 in deductible business operating expenses, and $18,000 in ongoing rental income from a residential duplex that a property manager runs and that will continue regardless of whether Liam can work. If the insurer's maximum insurable limit is 60% of eligible pre-tax earned income, what is the maximum annual disability benefit Liam can be underwritten for based on his earned income?

a. $84,000 per year, calculated as 60% of his $140,000 gross business revenue.
b. $54,000 per year: 60% of $90,000 net business income ($140,000 minus $50,000), with the $18,000 rent listed separately.
c. $64,800 per year, calculated as 60% of $108,000 ($90,000 net business income plus the $18,000 rental income).
d. $94,800 per year, calculated as 60% of $158,000 ($140,000 gross revenue plus $18,000 rental income).

93′. Maya, an independent bookkeeper, generates $110,000 in gross annual billings, incurs $30,000 in office and software expenses, and receives $12,000 per year in ongoing trust dividend distributions that continue even if she is disabled. Using a 60% insurable income ratio on eligible pre-tax earned income, what is her maximum annual insurable disability benefit?

a. $66,000 per year, based on 60% of her $110,000 gross annual billings.
b. $55,200 per year, based on 60% of $92,000 ($80,000 net business income plus $12,000 ongoing trust dividends).
c. $73,200 per year, based on 60% of $122,000 ($110,000 gross billings plus $12,000 ongoing trust dividends).
d. $48,000 per year, based on 60% of her $80,000 net business income, with the trust dividends left out.

94. According to the LLQP exam rules, when an eligible employee without a group short-term disability plan becomes unable to work due to illness and submits a medical certificate, what is the maximum benefit period and waiting period for Employment Insurance (EI) sickness benefits?

a. A maximum 15-week benefit period after a one-week waiting period.
b. A maximum 52-week benefit period after a two-week waiting period.
c. A maximum 12-month benefit period after a 90-day waiting period.
d. A maximum 24-month benefit period starting four months after the onset of severe and prolonged disability.

94′. Under the standard LLQP exam provisions, an employer designs its group disability program to coordinate with federal Employment Insurance (EI) sickness benefits. After the initial one-week waiting period, for how many maximum weeks does the exam state that EI sickness benefits will pay at 55% of insurable earnings?

a. Up to 4 weeks at 55% of insurable earnings.

b. Up to 15 weeks at 55% of insurable earnings.

c. Up to 60 weeks at 55% of insurable earnings.

d. Up to 104 weeks at 55% of insurable earnings.

95. Tariq earns a pre-disability gross salary of $6,000 per month ($72,000 per year). His employer's group long-term disability (LTD) plan pays 60% of gross monthly salary ($3,600) and includes an 85% all-source maximum based on pre-disability gross income, with no separate dollar-for-dollar CPP offset clause. Tariq also owns an individual disability policy paying $1,500 per month, and his group master contract includes individual disability benefits in the all-source maximum calculation. Once Tariq is approved for a $1,200 monthly CPP disability (CPP-D) benefit, how much will his group LTD plan pay him each month?

a. $3,600 per month, because neither CPP-D nor individual disability benefits reduce group LTD payouts.

b. $3,900 per month, calculated as the $5,100 all-source maximum minus the $1,200 CPP-D benefit.

c. $2,400 per month: the $6,300 total exceeds the $5,100 cap by $1,200, so group LTD drops from $3,600.

d. $2,100 per month, because the $1,500 individual policy is deducted dollar-for-dollar while CPP-D is ignored.

95′. Using the same pre-disability gross income of $6,000 per month, a 60% group LTD benefit ($3,600/month), a $1,200/month CPP-D benefit, and a $1,500/month individual disability policy, suppose the employer's group master contract explicitly exempts individual disability policies from the 85% all-source maximum pool (and has no separate dollar-for-dollar CPP offset). What is the total combined monthly nominal benefit Tariq receives from all three sources before income tax?

a. $6,300 per month: group plus CPP-D is $4,800, under the $5,100 cap, so LTD is unreduced and the exempt $1,500 is added.

b. $5,100 per month, because no claimant can ever receive more than 85% of pre-disability gross income from all policies combined.

c. $4,800 per month, because the individual disability policy refuses to pay whenever group LTD and CPP-D are active.

d. $5,700 per month, because half of the CPP-D benefit is deducted from the group LTD payout.

96. Devon, a long-haul transport driver, owns an individual disability insurance policy with a 120-day (approximately 4-month) waiting period and a 5-year (60-month) benefit period. After a severe spinal injury, Devon is continuously disabled and unable to work for 68 months. For how many total months will Devon receive disability benefit payments under this policy?

a. 56 months, because the 4-month waiting period is subtracted from the 60-month maximum benefit period.
b. 64 months, because subtracting the 4-month waiting period from the 68 months of disability leaves 64 payable months.
c. 60 months, starting at Month 5 after the 120-day waiting period and paying up to the full 60-month benefit period cap (Months 5 through 64).
d. 68 months, because once the 120-day waiting period is satisfied, benefits are paid retroactively from Day 1 for the entire disability.

96′. Sonia owns an individual disability policy with a 90-day (approximately 3-month) waiting period and a 2-year (24-month) benefit period. Following a serious illness, she remains continuously disabled for 30 months before recovering. How many months of disability benefits will Sonia collect in total?

a. 21 months, calculated by deducting the 3-month waiting period from the 24-month benefit period.
b. 24 months, beginning after the 3-month waiting period and paying for the full 24-month maximum benefit period.
c. 27 months, calculated by subtracting the 3-month waiting period from the 30-month total disability duration.
d. 30 months, covering every month she was unable to work.

97. Grace, a salon owner, holds an individual disability policy under which benefits start after 90 days and run for up to 24 months; its recurring disability clause uses a 6-month window. She becomes disabled due to a chronic illness, satisfies the 90-day waiting period, collects benefits for 14 months, and then returns to work full-time. After working for 4 months, she suffers a relapse from the exact same chronic illness and remains disabled for another 18 months. How will her insurer handle the second period of disability?

a. Waive the 90-day waiting period and pay benefits for up to 24 additional months because each relapse resets the benefit period.
b. Impose a new 90-day waiting period and then pay benefits for the remaining 10 months of the original benefit period.
c. Impose a new 90-day waiting period and reset the maximum benefit period to a fresh 24 months.
d. Waive the 90-day waiting period so benefits resume at once, but pay only 10 more months since 14 of the 24 have been used.

97′. Suppose Grace (same policy: benefits start after 90 days, run for up to 24 months, and relapses use a 6-month window) collected 14 months of benefits during her first disability, returned to full-time work for 7 months, and then suffered a relapse from the same chronic condition that lasted another 18 months. How will the insurer treat this second disability?

a. Waive the 90-day waiting period and pay only the remaining 10 months from the first claim's benefit period.
b. Treat it as a new disability: apply a fresh 90-day waiting period and reset the maximum benefit period to a full 24 months.
c. Waive the 90-day waiting period and also reset the maximum benefit period to a full 24 months.
d. Deny the second claim completely because the 6-month recurring disability window has expired.

98. Arthur, a 64-year-old corporate lawyer, holds an individual non-cancellable disability insurance policy that expires at age 65. Meanwhile, his younger associate, Ben, recently enrolled in a professional association disability plan advertised as guaranteed issue, which also states in the contract that the policy is cancellable. Which statement accurately describes their coverage rights?

a. Arthur loses all disability coverage permanently at age 65 with no conversion option, while Ben's guaranteed issue policy can never be terminated by the insurer.
b. Arthur can usually convert to guaranteed renewable at 65 without medical evidence, while Ben's guaranteed issue plan, being cancellable, can still be ended by the insurer.
c. Arthur can extend his non-cancellable policy to age 75 at his original locked-in premium rate, while Ben's premiums are locked in for life under guaranteed issue.
d. Both Arthur and Ben must pass a full medical examination at age 65 to keep any disability coverage in force.

98′. Dr. Evelyn is comparing two disability insurance offers: Plan X is an individual non-cancellable policy to age 65, and Plan Y is an association plan marketed as guaranteed issue with a cancellable renewal clause. Which statement correctly distinguishes the underwriting and renewability features of these two plans?

a. Guaranteed issue means Plan Y can never raise premiums or cancel coverage, which makes it identical to Plan X once the policy is issued.
b. Plan X allows the insurer to raise premiums across Evelyn's occupational class prior to age 65, whereas Plan Y locks in premiums permanently.
c. Plan X locks premiums and benefits to 65 with a usual medical-free conversion at 65; Plan Y's guaranteed issue applies only at entry, and it stays cancellable.
d. Neither Plan X nor Plan Y can be continued past age 65 under any circumstances unless Evelyn submits new medical evidence to the insurer.

Chapter 15 · Critical Illness & Long-Term Care Insurance Accident & Sickness

Items marked ′ are variants on the same point: do one when you miss the main question.

99. Victor, age 49, purchased a $150,000 critical illness (CI) insurance policy with a 30-day qualification period and a 30-day survival period. Six months after the policy took effect, Victor suffered a severe stroke that fully satisfied the contract's medical definition. He survived for 34 days following the diagnosis, submitted his claim forms, and then passed away from complications two days before the insurer finished processing the payout. Who is entitled to the $150,000 CI benefit?

a. No one, because a critical illness policy only pays benefits to a living insured and cancels any pending claim if death occurs before the cheque is issued.

b. Victor's estate or named beneficiary, because he satisfied both the qualification period and the 30-day survival period before he died.

c. No one, because a stroke requires a mandatory 90-day survival period whenever the insured is hospitalized in intensive care.

d. Victor's estate, but only a refund of premiums paid, because the qualification period restarts upon the date of diagnosis.

99′. Clara purchased a $200,000 critical illness (CI) policy with a 30-day qualification period and a 30-day survival period. Eight months after policy issue, she was diagnosed with a covered heart attack. Tragically, Clara passed away 19 days after the diagnosis. She did not purchase a return of premium on death (ROPD) rider. How will the insurer handle the $200,000 CI benefit claim?

a. Pay $200,000 to her beneficiary, because the heart attack occurred well after the 30-day qualification period had expired.

b. Pay a pro-rated benefit of 19/30 of $200,000 to her estate based on the days she survived after diagnosis.

c. Convert the $200,000 critical illness benefit into a tax-free life insurance death benefit automatically upon her death.

d. Pay no critical illness benefit, because she died before completing the required 30-day survival period following diagnosis.

100. Hannah is preparing for her licensing exam and reviewing how long-term care (LTC) insurance policies are structured in the exam. According to the standard exam rules, what is the typical elimination period range for an LTC policy, and how are home care versus facility care benefits generally categorized?

a. An elimination period of 0 to 90 days (where a shorter period means a higher premium), with home care generally using a reimbursement model and facility care using an indemnity model.

b. An elimination period of 365 or 730 days starting no earlier than age 65, with both home care and facility care strictly restricted to expense reimbursement.

c. A mandatory 30-day qualification period followed by a 30-day survival period, paying a single lump sum regardless of where care is received.

d. An elimination period of 0 to 90 days (where a shorter period means a lower premium), with home care using an indemnity model and facility care using a reimbursement model.

100′. An advisor is comparing two individual long-term care (LTC) insurance policies from the exam manual: Policy X has a 30-day elimination period and Policy Y has a 90-day elimination period. All other coverage terms are identical. Under the exam principles, which statement is correct regarding their premiums and benefit structure?

a. Policy Y has a higher premium than Policy X because the insured waits longer before benefits begin.

b. Neither policy is valid under the exam rules because the minimum elimination period for LTC insurance is 365 days.

c. Policy X has a higher premium than Policy Y because the insurer starts paying sooner, and both fit the exam's 0—90 day range.

d. Both policies charge the exact same premium because the elimination period only affects critical illness policies, not LTC policies.

101. Kevin, age 54, owns a 10-condition critical illness (CI) policy that covers stroke. Under the policy's stroke definition, transient ischemic attacks (TIAs) are explicitly excluded. One afternoon, Kevin experiences sudden slurred speech and weakness in his left arm. At the hospital, his symptoms completely resolve within 45 minutes, brain imaging shows no permanent neurological damage, and the attending physician records a diagnosis of TIA (commonly called a "mini-stroke"). How will the insurer respond to Kevin's CI claim?

a. Approve the full benefit, because a TIA is medically known as a mini-stroke and the policy covers stroke.
b. Approve 50% of the benefit, because temporary neurological symptoms automatically qualify as a half-stroke under industry law.
c. Deny the claim, because a TIA diagnosis does not meet the contract's definition of a covered stroke and is expressly excluded.
d. Defer the decision for 90 days and pay the full benefit as long as Kevin remains alive at the end of the waiting period.

101′. Nadia holds a basic critical illness policy covering four conditions, where the contract's cancer definition explicitly excludes non-invasive cancer in situ and early stage T1a prostate or skin lesions. Her dermatologist removes a superficial non-invasive lesion that pathology confirms is carcinoma in situ, and Nadia has no other partial-benefit riders. Why will her claim for the full critical illness benefit be denied?

a. Because carcinoma in situ is expressly excluded, so her diagnosis does not meet the contract's definition of covered cancer.
b. Because cancer is not one of the Big 4 conditions, so a four-condition basic plan never includes a cancer benefit.
c. Because surgical removal cured the lesion before the 30-day qualification period could even be calculated.
d. Because critical illness policies only pay when the insured is permanently unable to return to any work.

102. In 2021, Desmond was diagnosed with life-threatening colon cancer and received the full $100,000 lump-sum benefit under his standalone critical illness (CI) policy. Under the terms of his contract, full payment of the face amount terminates the policy, and Desmond had never added a second event rider. In 2025, Desmond suffers a major heart attack and contacts his insurer to claim another benefit under the same policy. What is the outcome?

a. He receives another $100,000 because heart attack and cancer are separate conditions within the Big 4 category.
b. He receives $50,000 because a second unrelated critical illness automatically pays half the original face amount.
c. He receives $100,000 minus the premiums he would have paid between 2021 and 2025 under the waiver of premium clause.
d. He receives nothing under that policy, because it terminated on the full payout in 2021 and he had no second event rider.

102′. Wendy holds a $250,000 critical illness policy that separates early-stage partial benefit conditions from full-payout conditions, and she also added a second event rider. Last year, she received an early-stage partial benefit that did not terminate her base contract. If she later claims for another condition under the policy or the second event rider, what principle applies?

a. Any small partial payout automatically terminates the entire critical illness contract, exactly as a 100% full claim would.
b. Her base coverage may stay in force after the partial payout, but a later claim must still meet condition definitions, interval rules and survival periods.
c. Having a second event rider guarantees an immediate payout for any future illness without needing to meet a survival period or medical definition.
d. The insurer will convert her remaining coverage into a disability income policy that pays monthly benefits until she reaches age 65.

103. Leonard, age 78, has a long-term care (LTC) insurance policy. Following a mild neurological episode, he has occasional difficulty finding the right words when speaking, but his memory, orientation, and reasoning remain intact and he does not require continual supervision. He can independently perform bathing, dressing, toileting, eating, and continence, and only needs minor help with transferring from bed to chair. Under the standard exam criteria for ADLs and cognitive impairment, does Leonard qualify for LTC benefits?

a. Yes, because any speech difficulty is automatically classified as severe cognitive impairment under LTC rules.
b. Yes, because needing assistance with even one activity of daily living, such as transferring, triggers full LTC benefits.
c. No, because only one of the six ADLs is affected (two are required) and he has no cognitive decline requiring continual supervision.
d. No, because an insured must lose all six ADLs simultaneously before an LTC policy will begin counting the elimination period.

103′. Evelyn, age 81, is physically healthy and can independently dress, bathe, use the toilet, transfer, eat, and maintain continence without any physical assistance. However, due to advanced Alzheimer's disease, she suffers severe cognitive deterioration and requires continual supervision to prevent her from wandering into traffic or leaving the stove on. After satisfying the policy's elimination period, is Evelyn eligible for long-term care (LTC) benefits?

a. Yes, because cognitive impairment requiring continual supervision is a separate trigger, even if she can still perform all six ADLs.
b. No, because an insured must always fail at least two physical ADLs in addition to having a cognitive impairment.
c. No, because Alzheimer's disease is only covered under a standalone critical illness policy, never under an LTC contract.
d. Yes, but only for a maximum of 30 days under the respite care clause, because she has no physical impairment.

104. Marcus is comparing critical illness (CI) insurance quotes from two different insurers. Both policies cover the "Big 4" conditions (heart attack, stroke, cancer, and coronary artery bypass surgery). Marcus asks his advisor whether the medical definition of "heart attack" is guaranteed to be identical in both policies because of the CLHIA CI Benchmark Definitions. What is the advisor's correct response?

a. Yes, every insurer operating in Canada is legally required by provincial legislation to copy the 2024 CLHIA benchmark definitions word for word.
b. Yes, for the Big 4 conditions the wording is strictly identical across all insurers, and differences only exist for extended conditions beyond the first four.
c. No, because adoption of the CLHIA benchmark definitions by insurers is voluntary, so the advisor must review the exact definition wording in each specific contract.
d. No, because the CLHIA benchmark definitions only apply to group disability insurance and have never covered critical illness policies.

104′. An advisor tells a client, "Every basic critical illness policy on the market must cover all four of the Big 4 conditions, and every insurer's contract uses the exact same definition threshold." Why is the advisor's statement inaccurate?

a. Because the Big 4 refers to four activities of daily living in long-term care insurance, not critical illness conditions.
b. Because some basic CI policies cover three or fewer conditions, and industry benchmark definitions are voluntary so exact contract wording varies by insurer.
c. Because Canadian insurers are only allowed to offer comprehensive 20+ condition policies and are banned from selling 3- or 4-condition plans.
d. Because critical illness definitions are set individually by the client's family physician at the time of claim rather than by the insurance contract.

105. Owen holds a reimbursement-style long-term care (LTC) policy with a daily maximum benefit of $150 and a nominal benefit period of 365 days, creating a total maximum benefit pool of $54,750 ($150 × 365). After satisfying the elimination period, Owen receives eligible home care that costs exactly $100 per day. Under the exam's benefit pool carry-forward rule, how much is reimbursed per day and how many days can Owen's total benefit pool last at this spending rate?

a. $150 per day for 365 days, because the insurer always pays the full daily maximum regardless of actual receipts.
b. $100 per day for 365 days only, with the unused $50 per day forfeited permanently at the end of the nominal 365-day period.
c. $50 per day for 1,095 days, because the insured must pay the first $100 per day as a continuing co-payment.
d. $100 per day for up to 547.5 days, because the unused $50 daily balance carries forward until the $54,750 total maximum benefit is exhausted.

105′. Vera has a long-term care (LTC) policy with a daily maximum benefit of $200 and a total maximum benefit pool of $146,000 (equivalent to 730 days at the maximum rate). After completing her elimination period, she incurs $160 per day in eligible home care expenses. Under the exam's carry-forward rule for unused daily benefits, how many days of care will her $146,000 total benefit pool fund if her daily cost remains $160?

a. 730 days, because the nominal day count can never be extended even when daily expenses are below $200.

b. 912.5 days, because the unused $40 per day remains in the pool until the full $146,000 maximum is spent ($146,000 ÷ $160).

c. 3,650 days, because the policy only pays the $40 difference between the $200 cap and the $160 invoice.

d. 584 days, because the $146,000 pool is reduced by 20% whenever the insured stays at home instead of entering a facility.

Chapter 16 · Extended Health, Dental, and Travel Insurance Accident & Sickness

Items marked ′ are variants on the same point: do one when you miss the main question.

106. Elena, an architect in Kelowna, incurs an $800 eligible bill for routine dental maintenance. Her personal dental insurance policy has an unused annual deductible of $100 and a co-insurance factor of 80% for routine maintenance, with sufficient annual maximum remaining. How much will the insurer reimburse, and how much must Elena pay out of pocket?

a. The insurer reimburses $640, and Elena pays only the $100 annual deductible out of pocket.

b. The insurer reimburses $560, and Elena pays $240 out of pocket ($100 deductible plus $140 co-insurance share).

c. The insurer reimburses $700, and Elena pays $100 out of pocket because the deductible replaces co-insurance.

d. The insurer reimburses $800, and Elena pays $0 out of pocket because routine dental maintenance is covered in full.

106′. Marcus, a graphic designer in Kamloops, submits an $800 eligible claim for a dental crown (major restorative work). His policy has an unused annual deductible of $100, covers routine maintenance at 80%, and covers major restorative work at a 50% co-insurance factor. Why does the insurer apply a 50% co-insurance factor instead of 80% after deducting the $100 deductible from the $800 bill?

a. Because provincial health care plans already pay the other 50% of major restorative crowns and bridges.

b. Because the $100 deductible was not paid upfront at the dental clinic through direct billing.

c. Because insurers raise the client's share on costlier, harder-to-predict restorative work to curb moral hazard.

d. Because any dental bill reaching $800 is automatically penalized for exceeding the provincial dental fee schedule.

107. Tariq has a dental plan that covers 80% of routine maintenance with no deductible, based on the provincial dental association fee schedule specified in his contract. His dentist charges more than the contract's fee schedule amount for a filling, leaving Tariq with a larger out-of-pocket bill than 20% of the clinic's invoice. Tariq complains that his insurer partially denied his claim. How should the advisor explain this outcome?

a. The insurer fulfilled its contract by paying 80% of the fee schedule amount; the excess charged by the dentist was never a covered expense and must be paid by Tariq.
b. The insurer improperly reduced the benefit because fillings are classified as major restorative work subject to a 50% co-insurance factor.
c. The dentist violated provincial health care regulations by charging above the fee schedule, so the provincial plan will reimburse the difference.
d. The insurer applied a hidden annual deductible because direct billing was used at the dental clinic instead of manual reimbursement.

107′. Simone's extended health plan covers prescription drugs according to a strict drug formulary that reimburses up to the cost of the lowest-priced generic equivalent. At the pharmacy, Simone insists on receiving the brand-name medication instead of the generic drug. How will the claim be settled?

a. The insurer will deny the entire prescription claim because choosing a brand-name drug voids formulary coverage.
b. The provincial Medical Services Plan (MSP) will automatically cover the price difference between the generic drug and the brand-name drug.
c. The pharmacy must waive the price difference whenever the insured presents a direct billing card at the counter.
d. The insurer will reimburse based on the eligible generic drug cost under the formulary, and Simone must pay the price difference out of pocket.

108. Devon, his spouse, and their child are covered under a group extended health plan with an individual annual deductible of $50 and a family annual deductible of $150. Earlier this year, Devon submitted $50 of eligible expenses and his spouse submitted $60 of eligible expenses. Today, their child submits $60 of eligible expenses. How is the deductible applied to the child's $60 claim, and what is the family's deductible status afterward?

a. Only $10 of the child's claim is applied to the deductible because the spouse's $60 claim already pushed the family total to $140.
b. All $60 of the child's claim is applied to the deductible, bringing the family deductible total to $170 for the year.
c. $50 goes to the deductible and $10 to co-insurance, bringing the family total to $150 and clearing the deductible for everyone this year.
d. None of it, because once two members each meet a $50 individual deductible, the $150 family deductible is waived.

108′. A family of several members is covered under a group extended health plan with an individual annual deductible of $50 per person and a family annual deductible of $150. Once three family members have each incurred $50 in eligible expenses during the calendar year, how will another family member's first eligible claim of the year be handled?

a. That member's claim bypasses the deductible entirely and goes straight to co-insurance because the $150 family deductible has already been satisfied.
b. That member must still pay a $50 individual deductible because every insured person must satisfy their own deductible regardless of family totals.
c. The family deductible automatically increases to $200 because each additional insured member adds $50 to the cap.
d. That member's claim is reimbursed at 100% with no co-insurance factor because satisfying the family deductible eliminates all cost sharing.

109. Arthur, aged 72, holds a multi-trip travel insurance policy that requires pre-existing medical conditions to be stable for 180 days prior to each departure. Exactly 130 days before leaving for a 90-day winter trip to Arizona, Arthur's cardiologist adjusted the dosage of his heart medication, which the policy defines as a change in treatment with no applicable exception. Assuming Arthur made no material misrepresentation on his application, what is the coverage outcome if he is hospitalized in Arizona first for a heart attack and later during the same trip for a broken leg from an accidental fall?

a. Both the heart attack claim and the broken leg claim are denied because violating the 180-day stability period voids the entire travel policy.
b. Both claims are paid in full because the 90-day trip duration is shorter than the 130 days that elapsed after the medication adjustment.
c. The heart attack claim is covered because exam rules cap all stability periods at 90 days, while the broken leg claim is subject to a 1-year waiting period.
d. Heart-related bills are denied because 130 days is short of the 180-day requirement, but the unrelated leg injury may still be covered.

109′. Clara, aged 69, plans a foreign trip and relies on the travel medical coverage included with her credit card rather than purchasing a standalone travel policy. Because the credit card did not require her to complete a detailed medical questionnaire when she paid for the trip, Clara believes her pre-existing chronic condition is unconditionally covered. How should her advisor clarify the risk structure of credit card travel insurance?

a. Credit card travel insurance never applies stability periods or age limits because underwriting is waived for all cardholders.
b. It still applies eligibility, age and trip-length limits and stability clauses, and the insurer checks medical records when a claim is made.
c. Credit card travel insurance covers trip cancellation and interruption only, and never includes emergency medical coverage outside Canada.
d. Under provincial health care rules, BC's Medical Services Plan (MSP) automatically pays 100% of any foreign hospital bill that a credit card policy denies.

110. Liam, a hospital technician in Victoria, reviews his employer's group extended health plan with his advisor. They identify five specific gaps: the group plan has no accidental death and dismemberment (AD&D) coverage, limits vision care to $100 every 24 months, caps lifetime orthodontics at $2,500 with 50% co-insurance, covers only semi-private hospital rooms, and excludes out-of-country travel medical insurance. What is the appropriate needs analysis recommendation?

a. Keep the group plan for its low cost and lack of medical underwriting, and add individual coverage that fills only the listed gaps.
b. Opt out of the employer group plan completely and replace it with a comprehensive individual plan so all coverage sits under one contract.
c. Demand that the group insurer modify the master contract exclusively for Liam to increase his vision and orthodontic limits.
d. Purchase a duplicate full-scope individual health plan that mirrors every benefit already in the group plan without listing specific gaps.

110′. Why do employer group extended health plans commonly leave gaps such as a $100 vision care limit every 24 months or 50% co-insurance on orthodontics, whereas individual extended health plans allow applicants to select higher customized limits?

a. Group plans are prohibited by provincial law from covering private hospital rooms, AD&D, or out-of-country travel medical expenses.
b. Group plans are employer-negotiated packages for a whole class at low cost with no underwriting; individual plans are tailored but usually underwritten.
c. Individual plans are subsidized by the Employer Health Tax (EHT), which allows private insurers to offer higher vision and dental maximums.
d. Group plans require every employee to pass full medical and financial underwriting before joining, forcing insurers to cap benefits.

111. Owen has an Accidental Death and Dismemberment (AD&D) rider attached to his policy. Under the policy's schedule of loss (which matches the standard exam illustration: 100% of the principal sum for loss of two limbs or sight in both eyes, 67% for loss of sight in one eye, 50% for loss of speech, and 33% for loss of hearing in one ear, provided the loss occurs within 365 days of the accident), Owen suffers an accident that permanently destroys the hearing in one ear 90 days after the injury. What percentage of the principal sum will the AD&D rider pay?

a. 100% of the principal sum, because any permanent dismemberment or sensory loss occurring within 365 days triggers the full benefit.

b. 67% of the principal sum, because all single-organ sensory losses are grouped under the same benefit tier.

c. 33% of the principal sum, because the loss occurred within the 365-day time limit and loss of hearing in one ear pays 33% under the schedule of loss.

d. 0% of the principal sum, because AD&D benefits are only payable if the specified loss occurs on the exact date of the accident.

111′. Using the same AD&D schedule of loss illustration (100% of the principal sum for loss of sight in both eyes; 75% for loss of one limb; 50% for loss of speech; 33% for loss of hearing in one ear; loss must occur within 365 days of the accident), what percentage of the principal sum is payable if the insured permanently loses speech 180 days after a covered accident?

a. 50% of the principal sum, because loss of speech within the 365-day window is paid at 50% on this schedule.

b. 75% of the principal sum, because loss of speech is paid at the same rate as the loss of a single limb.

c. 100% of the principal sum, because total loss of speech is complete and permanent rather than partial.

d. 0% of the principal sum, because the loss occurred more than 90 days after the covered accident happened.

112. Hannah, a healthy adult between the ages of 19 and 64 living in Vancouver, has no employer group benefits and relies solely on British Columbia's Medical Services Plan (MSP). This month, she visits her family physician for a medically necessary consultation, gets a routine eye exam at an optometrist's clinic, receives physiotherapy for a sprained wrist, and has a routine dental cleaning. Assuming she does not belong to any special supplementary assistance group, which of these expenses is paid by MSP?

a. The medically necessary family physician consultation and the routine eye exam, because MSP covers all physician and vision diagnostic services.

b. Only the medically necessary physician visit; MSP does not generally pay for the routine eye exam at her age, physiotherapy, or dental cleaning.

c. All four services, because British Columbia eliminated personal MSP premiums in 2020 and replaced them with universal comprehensive coverage.

d. The family physician consultation and the physiotherapy sessions, because only dental and cosmetic services are excluded from MSP.

112′. During a client meeting in Burnaby, an applicant asks why he would need private extended health insurance if Canada already has public health care and national pharmacare legislation. Which explanation by the advisor is accurate?

a. Public plans pay for medically necessary doctor and hospital care and some listed drugs, which still leaves gaps in dental, vision, paramedical and other drug costs.

b. Provincial governments provide zero funding for any prescription drugs, dental surgery in hospitals, or medical care outside a doctor's office.

c. Private extended health insurance is legally mandatory for all British Columbia residents ever since MSP personal premiums were eliminated in 2020.

d. Private extended health insurance is designed to replace lost employment income when an illness prevents the insured from working.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

113. Liam and Noah are equal co-owners of a commercial printing company that employs Elena, a master colour-calibration specialist whose unique skills generate 45% of the firm's contracts. Liam and Noah want insurance that will provide funds to recruit and train a temporary replacement if Elena suffers a disabling injury for eight months, and separate insurance to buy out Liam's or Noah's shares if either co-owner becomes permanently disabled for more than a year. Which combination of business disability policies addresses these two distinct exposures?

a. Key person disability insurance on Elena owned by the company, and disability buyout insurance on Liam and Noah linked to their buy-sell agreement.

b. Business overhead expense (BOE) insurance on Elena to reimburse her lost wages, and key person disability insurance on Liam and Noah to fund the share purchase.

c. Disability buyout insurance on Elena payable to her family, and business overhead expense (BOE) insurance on Liam and Noah to purchase the disabled partner's equity.

d. A Private Health Services Plan (PHSP) on Elena to cover recruitment costs, and a business loan protection disability policy on Liam and Noah to transfer their shares.

113′. Hannah is the sole owner of an accounting practice with three salaried bookkeepers, and her top tax manager, Lucas (who holds 0% equity), brings in most of the complex corporate audit engagements. If Hannah wants coverage that pays the office lease and bookkeepers' salaries while she herself is disabled for four months, plus coverage that compensates the firm for lost revenue if Lucas is disabled for six months, what policies should the practice purchase?

a. Disability buyout insurance on Hannah and business overhead expense (BOE) insurance on Lucas.

b. Business loan protection disability insurance on Hannah and a Private Health Services Plan (PHSP) on Lucas.

c. Business overhead expense (BOE) insurance on Hannah and key person disability insurance on Lucas, with the practice as policyowner and beneficiary of both.

d. Key person disability insurance on Lucas payable directly to Lucas's personal bank account, and individual disability insurance on Hannah to pay office rent.

114. Dr. Chloe owns a dental clinic that holds a business overhead expense (BOE) policy with a $10,000 monthly limit, a 24–month benefit period, and an unused–benefit carryover provision. After satisfying the waiting period, Dr. Chloe remains totally disabled. In Month 1 of benefits, the clinic incurs $8,500 in office rent, utility bills, staff wages, and commercial loan interest. In Month 2, the clinic incurs $9,200 in office rent, staff wages, and utilities, plus $1,500 in commercial loan interest, $2,000 in commercial loan principal repayment, and $6,000 for Dr. Chloe's own monthly salary draw. How much will the BOE policy reimburse for Month 2?

a. $10,000, because the policy never pays more than the monthly limit in any single month regardless of prior unused room.

b. $10,700: the $9,200 of rent, wages and utilities plus $1,500 of loan interest, paid from the $10,000 cap and $700 of Month 1's carryover.

c. $11,500, because the clinic can claim the full $10,000 monthly cap plus the entire $1,500 carryover by including the $2,000 loan principal repayment.

d. $16,700, because Dr. Chloe's $6,000 salary draw is a regular monthly payroll expense that can be reimbursed out of the $240,000 total benefit pool.

114′. An optometry clinic carries a business overhead expense (BOE) policy with a $6,000 monthly cap and a carryover provision. After the waiting period ends, the clinic incurs $5,100 of eligible fixed expenses in Month 1. In Month 2, the clinic records $5,800 in office rent and employee wages, $700 in commercial loan interest, $1,200 in commercial loan principal, and $3,500 for purchasing a new diagnostic camera. How much will the BOE policy reimburse for Month 2?

a. $6,500, using the $6,000 Month 2 limit plus $500 from Month 1's $900 unused carryover to cover rent, employee wages, and loan interest.

b. $6,000, because BOE policies cap every single month strictly at the stated monthly limit without inter–month adjustments.

c. $6,900, because the $1,200 loan principal pushes eligible expenses above $6,900 and exhausts the entire $900 carryover from Month 1.

d. $10,000, because the new diagnostic camera is an operational tool reimbursable from the total benefit pool.

115. Mateo's manufacturing firm has a commercial bank loan with monthly payments consisting of $1,800 in interest and $3,200 in principal. Mateo purchases both a business overhead expense (BOE) policy and a business loan protection disability insurance policy. Which statement correctly describes the income tax treatment and claim coordination of these two policies?

a. Both policies have tax–deductible premiums and pay tax–free benefits, so Mateo can claim the same $1,800 of monthly loan interest under both policies at once.

b. BOE premiums are non–deductible with tax–free benefits, whereas business loan protection DI premiums are tax–deductible with taxable benefits.

c. BOE premiums are deductible and its benefits taxable; loan protection DI premiums are non–deductible and its benefits tax–free; the same loan interest cannot be claimed under both.

d. BOE covers both the $1,800 interest and the $3,200 principal on a tax–free basis, making the business loan protection DI policy completely unnecessary.

115′. Sonia owns a bakery that pays $2,500 per month ($900 interest and $1,600 principal) on a commercial oven financing loan. Her accountant asks how the tax rules treat premiums and payouts if the bakery buys a business loan protection disability policy versus a business overhead expense (BOE) policy. Which explanation is accurate?

a. Loan protection DI has non–deductible premiums and tax–free benefits for qualified principal and interest; BOE has deductible premiums and taxable benefits and covers only the interest, never both on one loan.

b. Business loan protection DI premiums are fully deductible because loan interest is deductible, making its benefits taxable to the bakery.

c. BOE premiums are non–deductible, and BOE guarantees a zero net tax effect in every calendar year regardless of when expenses are recognized.

d. The bakery can deduct the BOE premiums, claim the $900 of interest under BOE, and at the same time claim the full $2,500 monthly payment under the business loan protection DI policy as well.

116. Apex Robotics Inc. wants to insure its lead firmware architect, Tariq, who holds 15% of the company's shares and earns $144,000 per year ($12,000 per month). If Tariq becomes disabled, the company estimates it will take up to 10 months and significant executive-search and double-salary training costs to find and onboard a temporary replacement. Based on exam conventions for key person disability insurance, how should this coverage be structured?

a. Tariq is automatically disqualified from key person disability coverage because any shareholding between 10% and 50% makes an employee ineligible across all insurers.
b. The policy should be owned by Tariq with benefits payable to his spouse for up to 5 years, with the amount calculated using the long-term gross profit contribution method borrowed from key person life insurance.
c. The company owns the policy and is its beneficiary, with a 30-to-90-day waiting period, a benefit period of up to 12 months within the usual cap (about $15,000/month or 100% of salary), and a replacement expense rider.
d. The company should use a 24-month waiting period before any key person benefits begin, matching the standard elimination period of disability buyout insurance.

116′. BioLab Corp. relies heavily on Dr. Lin, a research director who owns 12% of the company and earns $180,000 annually ($15,000/month). Which statement accurately reflects how key person disability insurance applies to Dr. Lin under the exam's rules?

a. Because key person life insurance and key person disability insurance share the same name, both use a 10-year gross profit multiple and pay benefits until age 65.
b. BioLab owns the policy and collects benefits for a short period (often up to 12 months after a 30-to-90-day wait), and may add waiver, recurrent disability and replacement expense riders.
c. The $15,000 monthly benefit must be paid directly to Dr. Lin tax-free to replace her personal household income while she recovers.
d. Every insurer in Canada enforces a single statutory shareholding cap of 10%, so Dr. Lin's 12% stake makes her legally uninsurable as a key person.

117. Arthur and Bernard are equal co-owners of an engineering firm valued at $1,600,000 ($800,000 per partner). Five years ago, they signed a buy-sell agreement funded by disability buyout insurance with an initial $800,000 limit on each partner, a 12-month waiting period, and the exam's standard post-age-60 reduction provision (20% per year after age 60). At age 62, Arthur suffers a stroke, cannot perform his regular occupation, is not working in any capacity, and triggers the buyout after completing the waiting period. Based on the exam's reduction example, how does the policy respond?

a. The policy pays the full $800,000 initial face amount because disability buyout policies lock in a level benefit until age 71.

b. The policy pays nothing because Arthur could theoretically do part-time administrative consulting from home, even though he is not working at all.

c. The policy starts the 12-month waiting period from the date Arthur was first diagnosed with high blood pressure two years earlier, rather than from the date he met the policy's disability definition.

d. Because the coverage reduces by 20% per year after age 60 in the exam model, the available buyout benefit at age 62 is discounted from the original $800,000, leaving an unfunded gap under the buy-sell agreement.

117′. Two CPA partners, Evelyn and Grace, hold disability buyout policies with a 360-day waiting period and the exam's post-age-60 reduction rule (20% per year after age 60). Evelyn is diagnosed with a progressive neurological condition at age 60, continues working full-time until she finally stops working and meets the policy's disability definition at age 61, and completes the 360-day waiting period at age 62. Meanwhile, her partner Grace asks whether Evelyn could still trigger the buyout if Evelyn worked part-time as a paid university lecturer during recovery. Which statement is correct?

a. The 360-day wait runs from age 61, when she stops working and meets the definition (not the age-60 diagnosis); her cover is reduced 20% a year after 60; and paid lecturing would breach the not-working-at-all test.

b. The waiting period starts on the age-60 diagnosis date even while Evelyn works full-time, so full unreduced benefits are payable on her 61st birthday.

c. Because disability buyout policies use a pure own-occupation definition, Evelyn can work full-time as a paid lecturer and still collect the full buyout benefit.

d. If the firm selects the 60-month installment payout option, Grace must first pay Evelyn personally out of Grace's own savings, and the insurer reimburses Grace only after the full five years.

118. An LLQP candidate is studying the disability risk statistics cited in the exam reference manual for 45-year-old business owners before age 65. According to the exam wording (based on the 1985 Commissioner's Disability Table), what are the approximate probabilities of a disability lasting 90 days or more for a single 45-year-old owner versus at least one of two 45-year-old co-owners, and what is the average duration?

a. About 15% for a single owner, about 30% for at least one of two co-owners, with an average duration of 1.2 years.
b. About 40% for a single owner, about 62.5% for at least one of two co-owners, with an average duration of 3.2 years.
c. About 62.5% for a single owner, about 90% for at least one of two co-owners, with an average duration of 5.0 years.
d. About 20% for a single owner, about 40% for at least one of two co-owners, with an average duration of 2.0 years.

118′. Two 45-year-old business partners ask their advisor how likely it is that at least one of them will suffer a disability lasting 90 days or longer before age 65, and how long such a disability lasts on average according to the LLQP exam reference material. Which figures reflect the exam's cited 1985 table?

a. A 40% probability that both partners will be disabled simultaneously, lasting an average of 12 to 24 months.
b. A 50% probability for at least one partner, matching the upper shareholding cap for key person disability insurance, lasting an average of 1.0 year.
c. A 20% probability for at least one partner, lasting an average of 60 months.
d. About 62.5% that at least one of the two will have a 90-day-plus disability before 65, lasting 3.2 years on average (versus about 40% for one owner).

119. A growing software firm with 18 employees wants to provide disability and health benefits specifically for its four senior vice-presidents without purchasing a traditional group insurance policy, and also wants to understand the difference between a grouped individual disability plan, a Private Health Services Plan (PHSP), and an Employee Life and Health Trust (ELHT). Which statement accurately describes these arrangements?

a. A grouped DI/CI plan buys individual policies for a defined class of employees (such as all senior vice-presidents), not hand-picked individuals, and a PHSP reimburses eligible medical costs, not lost income.

b. A grouped disability plan allows the employer to arbitrarily pick one favourite junior clerk and one vice-president without defining an objective employee class.

c. A Private Health Services Plan (PHSP) pays monthly tax-free cash benefits to cover the software firm's office lease and utility bills whenever one of the senior executives is disabled.

d. Any Health and Welfare Trust (HWT) that did not convert to an ELHT under Income Tax Act s.144.1 by the end of 2021 was automatically seized by the government and declared illegal.

119′. An engineering firm is reviewing its employee benefit structures: it wants to offer individual critical illness and disability policies to its entire class of licensed project managers, maintain a Private Health Services Plan (PHSP) for dental and prescription drug bills, and check the tax status of an Employee Life and Health Trust (ELHT). Which statement is correct under the lecture's rules?

a. The PHSP can be used to pay a disabled project manager's monthly salary and the firm's commercial loan interest.

b. Every PHSP in Canada is subject to one universal statutory contribution cap of $1,500 per adult and $750 per child, regardless of whether it covers arm's-length employees or self-employed owners.

c. Buying individual DI/CI policies for a defined class is a grouped plan, the PHSP pays medical costs outside public coverage, and ELHTs fall under Income Tax Act s.144.1 since the old HWT rules ended after 2021.

d. A grouped disability/CI plan is simply a standard group master policy where employees receive certificates rather than individual contracts.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

120. Julian is a self-employed landscape contractor whose financial statements show $72,000 in gross business revenue, $12,000 in operating expenses (leaving $60,000 in net business income), and $6,000 in dividends from a passive investment portfolio. Less than 12 months ago, he registered with the Canada Employment Insurance Commission via My Service Canada Account (MSCA) for Employment Insurance (EI) special benefits. If Julian is injured off the job today and cannot work, how should his agent assess his insurable earned income and his current EI sickness benefit eligibility?

a. $60,000 of net business income (the $6,000 of dividends is recorded separately), and no EI sickness claim is possible yet because the 12-month registration wait has not passed.

b. His insurable earned income is $72,000 based on gross business revenue, and he qualifies for EI sickness benefits immediately because his prior-year earnings exceeded the $9,254 self-employed threshold.

c. His insurable earned income is $66,000 by combining net business income with investment dividends, and he can cancel his EI registration at any time after claiming benefits without penalty.

d. His insurable earned income is $60,000, and he can collect EI sickness benefits immediately because the 12-month waiting period runs from the date he first opened his business.

120′. Hannah is a self-employed interior designer whose past three years of tax returns average $60,000 in net business income ($5,000 per month) after deducting studio overhead, plus $6,000 in ongoing rental income from a property. She registered for EI special benefits within the past 60 days and has never filed a claim, but she now prefers to rely on an individual disability insurance policy and a business overhead expense (BOE) policy instead. Which statement accurately describes her profile?

a. Her rental income is added directly to her net business income to raise her insurable earned income, and her EI registration is permanently irrevocable the moment she signs the online agreement.

b. She has no need for a separate business overhead expense (BOE) policy because a personal disability income policy automatically reimburses studio rent and staff wages.

c. Insurable earned income rests on the $60,000 net business income (rent listed separately), and since she is within 60 days and has never claimed, she may withdraw from EI owing no premiums.

d. Her insurable earned income is $60,000, and she is already eligible to claim EI sickness benefits today because her net self-employed income exceeds $9,254.

121. Carmen is a full-time salaried bookkeeper whose employer does not offer a group short-term disability plan. She is hospitalized for a serious non-occupational illness and applies for federal Employment Insurance (EI) sickness benefits. According to the standard LLQP exam (2022 exam benchmark), what is the maximum duration of EI sickness benefits and the basic earnings replacement rate?

a. Up to 15 weeks at 60% of average insurable weekly earnings.
b. Up to 15 weeks at 55% of average insurable weekly earnings.
c. Up to 26 weeks at 85% of pre-disability net earnings.
d. Up to 52 weeks at 90% of net insurable earnings.

121′. Trevor is a salaried warehouse supervisor who has accumulated 600 insurable hours over the past 52 weeks and experienced a weekly earnings reduction of more than 40% due to illness. However, his employer provides a group short-term disability (STD) plan that pays 60% of his $6,000 monthly salary ($3,600 per month), which is well above the Employment Insurance (EI) 55% replacement rate and weekly cap ($729 current / $638 exam benchmark). When profiling Trevor's government coverage, how should the agent view EI sickness benefits?

a. Whatever the week limit (15 on the exam, 26 today), EI pays second to an employer plan, so Trevor may get nothing from EI because his STD already exceeds the EI maximum.
b. Trevor will receive both his full 60% employer STD benefit and the full 55% EI sickness benefit because he has met the 600-hour qualification threshold.
c. EI is the first payor ahead of all employer group STD plans, so the employer plan is completely cancelled while EI pays.
d. Trevor can force his employer's STD plan to extend its minimum benefit period from 15 weeks to 26 weeks because the EI Premium Reduction Program automatically mirrors the 26-week sickness limit.

122. Valerie is an accountant in Burnaby earning a gross annual salary of $72,000 ($6,000 per month). She is covered by her employer's group long-term disability (LTD) plan, which provides a nominal benefit equal to 60% of pre-disability gross salary. Her employer pays 100% of the LTD premiums. Assuming an effective tax rate of 25% applies to both her regular salary and any taxable disability benefits, what is Valerie's net monthly disability benefit and her real after-tax income replacement ratio?

a. $3,600 net monthly benefit, resulting in an after-tax income replacement ratio of 80%.
b. $2,700 net monthly benefit, resulting in an after-tax income replacement ratio of 50%.
c. $2,700 net monthly benefit, resulting in an after-tax income replacement ratio of 60%.
d. $4,500 net monthly benefit, resulting in an after-tax income replacement ratio of 85%.

122′. Suppose Valerie's colleague, Derek, also earns a gross monthly salary of $6,000 with a 25% effective tax rate (giving him $4,500 in net monthly income), and his group LTD plan also pays a nominal 60% of gross salary ($3,600 per month). However, under Derek's plan structure, the employees pay 100% of the LTD premiums themselves through after-tax payroll deductions. What is Derek's after-tax income replacement ratio from the group LTD plan alone?

a. 60%, because the nominal percentage stated in a group policy always equals the after-tax replacement ratio.
b. 80%, because his $3,600 monthly LTD benefit is received tax-free and replaces $3,600 of his $4,500 after-tax monthly income.
c. 55%, because all tax-free group disability plans are capped at the Employment Insurance replacement rate.
d. 85%, because all group long-term disability plans automatically top up tax-free benefits to the all-source maximum.

123. Felix is a powerline technician earning $6,000 in gross monthly salary, and his minimum monthly household living expenses are $4,500. His employee-paid group long-term disability (LTD) plan pays a tax-free benefit of 50% of gross salary ($3,000/month) and contains a direct dollar-for-dollar offset for Canada Pension Plan disability (CPP-D) benefits. After the LTD waiting period, Felix is approved for a gross monthly CPP-D benefit of $1,234.68, which is subject to a 25% effective tax rate (leaving $926.01 net). Assuming no EI benefits apply, what is Felix's total net monthly disability income and his monthly income gap once CPP-D begins paying?

a. Total net monthly income of $3,926.01 and a monthly gap of $573.99 because CPP-D is added on top of the full $3,000 LTD benefit.
b. Total net monthly income of $3,000.00 and a monthly gap of $1,500.00.
c. Total net monthly income of $1,765.32 and a monthly gap of $2,734.68.
d. Total net monthly income of $2,691.33 and a monthly gap of $1,808.67.

123′. Consider Felix during Stage 1 of his claim—after his group LTD waiting period has ended and his tax-free $3,000/month LTD benefit has started, but before his CPP-D application has been approved or reached its start date (the fourth month after the month of disability). Assuming his minimum monthly household need is $4,500 and no EI is payable, what is Felix's monthly gap during Stage 1, and how should the agent design his individual coverage recommendation across both stages?

a. His Stage 1 gap is $1,500; it widens to $1,808.67 once the taxable CPP-D offset starts, so coverage should be sized to the largest gap on the timeline.
b. His Stage 1 monthly gap is $1,808.67 because the group insurer deducts an estimated CPP-D amount starting on the very first day of the injury.
c. His Stage 1 monthly gap is $1,500, and once CPP-D is approved in Stage 2 the direct offset is waived because his total income is below the 85% all-source maximum.
d. His Stage 1 monthly gap is $1,000 because CPP-D is guaranteed to pay retroactively from the date of diagnosis without tax.

124. Elena is a freelance translator whose average net business income over the past three years suggests a disability insurance need of $3,000 per month under the 60% income approach. However, when her agent tallies Elena's actual rent, groceries, utilities, and tax reserves under the expense approach, the minimum required amount is $2,000 per month. Elena wants coverage but says the premium for a $3,000 monthly benefit exceeds what she can afford right now. How should the agent proceed, and which financial statements verify her waiting-period buffer versus her monthly premium budget?

a. Insist on the $3,000 income approach figure or decline the file, using the cash flow statement to measure her liquid reserves and the net worth statement to track her monthly surplus.
b. Place $2,000 of expense-based coverage now with a future purchase option, using the net worth statement for the waiting-period buffer and the cash flow statement for premium affordability.
c. Rely exclusively on her net worth statement to determine both the monthly benefit amount and her monthly premium budget, ignoring the expense approach.
d. Recommend that she liquidate her Registered Disability Savings Plan (RDSP) to pay for the $3,000 policy, using her T4 slip to verify her fluctuating freelance income.

124′. Marcus is a salaried project manager reviewing his disability insurance profile. He asks his agent two specific questions: first, whether he has enough liquid savings and unencumbered assets to survive a 120-day waiting period before benefits begin; and second, which discretionary monthly outlays he can trim so he can afford the monthly policy premium. Which pair of financial statements answers Marcus's first and second questions, respectively?

a. The cash flow statement answers whether he can survive the 120-day waiting period, and the net worth statement shows which monthly expenses he can trim.
b. The employer's group benefits booklet answers both questions by specifying the 85% all-source maximum.
c. His corporate financial statements answer the first question, and the 60% income approach formula answers the second question.
d. The net worth statement answers whether he can self-fund the 120-day wait, and the cash flow statement shows where his monthly budget has room for the premium.

125. Liam and Noah are two warehouse managers in Coquitlam, each earning a gross monthly salary of $5,000 ($3,000/month disability need under the 60% income approach). Liam is single with no other household income. Noah lives in a dual-earner household with his spouse, Maya, whose stable salary theoretically covers most of the household bills, leaving Noah with a theoretical disability gap of only $1,000 per month. When the agent advises Noah on how much disability coverage to apply for compared with Liam, what caution from the exam applies?

a. Noah may buy less than Liam, but should keep a buffer above the bare $1,000 gap, since Maya may have to cut back or stop work to care for him.
b. Noah must purchase the exact $1,000 theoretical gap because insurers prohibit dual-earner spouses from insuring more than $1,000 of their monthly salary.
c. Liam can safely insure far less than $3,000 per month because single individuals automatically receive double the 55% Employment Insurance sickness benefit rate.
d. Maya's salary is classified as Noah's insurable earned income, allowing Noah to apply for a disability benefit equal to 60% of their combined household salaries.

125′. Priya is a single software engineer earning $5,000 per month with no dependents and no group disability coverage. Her sister, Taran, also earns $5,000 per month with no group coverage, but Taran's spouse earns a steady income that covers most of their shared mortgage and living costs, leaving a theoretical gap of $1,000 per month. If both sisters ask why their recommended disability insurance amounts differ despite identical salaries, which explanation is accurate?

a. Both sisters must purchase the exact same $3,000 monthly benefit because family structure and spousal income are irrelevant at every stage of the client profiling process.
b. Taran needs more disability coverage than Priya because her spouse's salary triggers a mandatory dollar-for-dollar offset under every individual disability policy she might buy.
c. Priya has no second earner and needs the full $3,000/month, while Taran's spouse partly replaces income—but Taran should still keep a cushion above the $1,000 gap in case care duties stop that income.
d. Priya can rely on the EI Family Supplement to top up her income, whereas Taran is disqualified because she is married.

126. Lucas, a commercial electrician in Surrey who meets age and contribution rules, suffers a back injury while rewiring a retail store on the job. He files a wage-loss claim with provincial workers' compensation (WorkSafeBC) and asks his insurance agent whether he should also count on immediate Canada Pension Plan disability (CPP-D) benefits in his financial profile, given that his doctor confirms it is a temporary injury and he will return to full-time electrical work after a brief recovery. How should the agent evaluate Lucas's government benefit profile?

a. He qualifies for CPP-D immediately because any occupational injury covered by workers' compensation automatically satisfies the CPP-D medical test.
b. He is barred from claiming provincial workers' compensation because the exam states that federal EI sickness benefits must pay the first 15 weeks of any workplace injury.
c. The injury belongs to workers' compensation (tax-free, about 90% of net income in BC; 80%—90% on the exam), and a temporary injury fails the 'prolonged' test for CPP-D.
d. His routine dental crown repair after the fall will be fully reimbursed by the British Columbia Medical Services Plan (MSP) at any neighbourhood dental clinic, as highlighted in the LLQP exam.

126′. Suppose Lucas's coworker, Quentin, suffers a permanent, career-ending spinal cord injury in the same workplace accident and his physician certifies that the condition is both severe and prolonged (indefinite duration, incapable regularly of pursuing any substantially gainful occupation). When profiling Quentin's cash flow during the first few months after the injury, how should the agent account for CPP-D alongside provincial workers' compensation?

a. List the maximum monthly CPP-D amount ($1,741.20) as tax-free cash flow starting on the date of the accident, on top of his full workers' compensation benefit.

b. Treat them as separate programs that may run concurrently, list CPP-D as pending until approved (paid from the fourth month after disability), and check offset rules instead of adding gross amounts.

c. Advise Quentin not to apply for workers' compensation because its 80%—90% benefit is fully taxable and would disqualify him from claiming the Disability Tax Credit (DTC) in future years.

d. Assume that because the LLQP exam never names WorkSafeBC, provincial workers' compensation benefits are ignored in all gap analysis calculations.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

127. Helena, a freelance graphic designer, was severely injured in an accident and remained hospitalized and unable to manage her affairs until day 45, when she immediately sent written notice of claim to her individual disability insurer. Based on the standard exam rules for statutory conditions, how is her claim affected?

a. Not forfeited if 30–day notice was not reasonably possible and she gave it as soon as she could, within the relief limit (6 months on the exam, 1 year in BC law); proof is still due in 90 days.

b. Her claim is automatically forfeited because the 30–day statutory period for written notice of claim is an absolute deadline with no exceptions.

c. She complied with the initial deadline because the statutory period for giving initial written notice of claim is 90 days, followed by a further 90 days for submitting proof.

d. Her claim remains valid, but the insurer will reduce her monthly disability benefit on a pro–rata basis under the change of occupation clause.

127′. Marcus developed a disabling illness and submitted written notice of claim to his individual disability insurer on day 15. By what statutory deadline from the date the claim arose must he submit written proof of claim, and what is the exam rule if submitting on time is not reasonably possible?

a. Written proof must be submitted within 30 days of the notice date, and any delay beyond 30 days permanently voids the claim.

b. Written proof must be submitted within 60 days from the end of the elimination period, with no statutory relief for late submission.

c. Written proof is due within 90 days of the claim arising, with late relief up to 6 months on the exam (1 year in BC law) if not reasonably possible.

d. Written proof must be submitted within 15 days after the insurer mails the claim forms, or the policy is terminated by registered mail.

128. When Victor purchased his individual disability insurance policy, he worked as an office administrator. Two years later, he switched to a higher-risk occupation as a commercial roofer without notifying the insurer, and he was subsequently injured on the job. Under Statutory Condition 3, how will the insurer handle his claim?

a. The insurer will deny the claim completely and void the contract for failure to disclose a change to a more hazardous occupation.

b. The insurer will pay the reduced benefit amount that the original premium paid would have purchased at the premium rate for the new, higher-risk occupation.

c. The insurer must pay the full face amount because the two-year statutory incontestability period has already expired.

d. The insurer will suspend claim payments until Victor pays two years of retroactive extra premiums plus interest within a 30-day grace period.

128′. Nadia bought an individual disability policy while working as a bookkeeper. She later became a logging site supervisor, a more hazardous occupation class, without informing her insurer. If she becomes disabled, what is the legal effect under the statutory change of occupation clause?

a. Her benefit becomes what her actual premium would have bought at the insurer's rate for the logging supervisor occupation.

b. Her policy is terminated immediately upon claim submission because moving to a higher-risk job breaches a material condition of the contract.

c. Her elimination period is automatically extended from 30 days to 120 days while keeping the original monthly benefit unchanged.

d. Her claim is denied unless the disability occurred entirely off the job and had no connection to her logging duties.

129. A self-employed architect wants individual disability coverage with an own-occupation definition, a 30-day elimination period, and a benefit period to age 65, but the premium exceeds his budget. The advisor considers four ways to lower the premium. Which adjustment carries the greatest risk of losing coverage altogether when his health declines?

a. Extending the elimination period from 30 days to 90 days while keeping the contract guaranteed renewable.

b. Shortening the benefit period from age 65 to 5 years while keeping the contract non-cancellable.

c. Switching from guaranteed renewable to cancellable, so the insurer keeps a Condition 4 right to terminate.

d. Changing the contract from non-cancellable to guaranteed renewable so the insurer can adjust premiums by class.

129′. Clara holds a guaranteed renewable individual disability policy, while her colleague holds a non-cancellable policy. Five years after issue, the insurer experiences higher-than-expected claims across their entire occupational class. What action is the insurer permitted to take regarding Clara's policy?

a. The insurer can unilaterally terminate Clara's policy by giving 15 days' notice by registered mail or 5 days' personal notice.
b. The insurer cannot terminate Clara's policy unilaterally, but it may increase premiums for all policyowners in her entire underwriting class.
c. The insurer cannot change Clara's premium at all because guaranteed renewable and non-cancellable policies both lock in premiums until age 65.
d. The insurer can single out Clara for an individual premium surcharge if she filed a claim during the previous two years.

130. Gavin is disabled and files a valid notice of claim under his individual disability policy. Once he submits satisfactory written proof of claim for his loss of income, what are the insurer's statutory obligations regarding claim forms, the initial payment, and ongoing payments under Statutory Conditions 6 and 9?

a. Provide claim forms within 30 days of notice, make the first loss-of-income payment within 90 days of proof, and pay every 90 days thereafter.
b. Provide claim forms within 5 days of notice, wait until the disability ends to verify total loss, and pay a single lump sum within 60 days.
c. Provide claim forms within 15 days of notice, make the initial loss-of-income payment within 60 days of proof, and pay every 30 days thereafter.
d. Forms within 15 days of notice, the first loss-of-income payment within 30 days of proof, then payments at least every 60 days while liability continues.

130′. An insurer decides to terminate a cancellable individual accident and sickness contract at renewal. Under Statutory Condition 4, what advance notice must the insurer provide to the insured?

a. At least 15 days' notice by registered mail or 5 days' written notice personally delivered.
b. At least 30 days' notice by regular mail or 15 days' notice personally delivered, matching the statutory grace period.
c. At least 60 days' notice by registered mail or 30 days' notice personally delivered, matching the claim payment intervals.
d. At least 90 days' written notice before the policy anniversary date, matching the proof of claim period.

131. Liam is resigning from his employer and wants to convert his group disability coverage to an individual policy without providing evidence of insurability. Considering the exam discrepancy (30 days in Chapter 2 versus 31 days in Chapter 7) and real-world practice, what is the proper rule regarding the conversion window?

a. On the exam, follow the specific number stated in the question stem (30 or 31 days); in practice, verify the exact conversion terms written in the client's specific group plan document.
b. Statutory Condition 5 sets a mandatory 90-day conversion window for all group accident and sickness plans across the province.
c. The advisor should always guarantee a 31-day window without checking the group booklet because group life insurance rules automatically govern group disability plans.
d. The conversion window is always 6 months under the exam rule and 1 year under the provincial statute.

131′. Sonia is leaving her company and asks her advisor how many days she has to apply for an individual disability policy under her group plan's conversion privilege, and she does not have her group booklet with her right now. How should the advisor handle the conversion deadline?

a. Tell her she has 90 days under Statutory Condition 5 because statutory conditions override all group disability contracts.
b. Assure her that provincial reinstatement legislation guarantees a 2-year window to convert any group disability coverage that terminated when she left her employer.
c. Assume the deadline is 60 days based on Statutory Condition 8 for non-income claims and tell her there is no rush.
d. Check her plan's conversion document or HR summary (the exam cites both 30 and 31 days) and use the shorter period until the document is in hand.

132. An advisor unconditionally delivers an individual accident and sickness policy to Trevor, who has not experienced any change in insurability, but Trevor's initial premium cheque has not yet been paid. Two days later, Trevor suffers an accidental injury. Under BC accident and sickness legislation (section 106(1)), is the insurer bound by the contract?

a. No, because under life insurance section 39 rules, no insurance contract can ever take effect until the initial premium is paid in full.
b. Yes; a delivered accident and sickness policy binds the insurer even though the first premium is unpaid, and the insurer can recover that premium.
c. No, because the 10-day client review period suspends the insurer's liability until the 10 days have expired.
d. Yes, but only if Trevor applies for statutory reinstatement within a 30-day or 2-year life insurance reinstatement window.

132′. Elena's individual disability policy lapsed after she missed a renewal premium and the 30-day statutory grace period expired. She asks her advisor what the statutory deadline is to reinstate her accident and sickness policy. What is the accurate rule?

a. She has a mandatory 2-year statutory window to reinstate the policy under section 57 of the Insurance Act.
b. She has a mandatory 90-day statutory window to reinstate, matching the proof of claim period under Statutory Condition 5.
c. There is no uniform statutory window as in life insurance; reinstatement depends on the contract, while section 113 applies disclosure and the two-year contest period from reinstatement.
d. Once the 30-day grace period expires, an accident and sickness contract is permanently prohibited by statute from ever being reinstated, whatever the policy terms might say.

133. Dr. Aris, a specialized hand surgeon, is comparing individual disability insurance options with a 90-day elimination period and a 5-year benefit period. Why would Dr. Aris pay a higher premium to select an own-occupation definition of disability rather than an any-occupation definition, and how does the 90-day elimination period affect his 5-year benefit period?

a. Own-occupation pays only if he cannot perform any job suited to his education, and the 90-day elimination period is deducted from the 5-year benefit period.
b. Own-occupation pays if he cannot do the main duties of his surgical specialty even while earning from teaching, and the 90-day wait does not shorten the 5-year benefit period.
c. Own-occupation automatically waives the two-year incontestability period under section 112, and the 90-day elimination period extends the benefit period to age 65.
d. Own-occupation is the cheapest option designed for self-employed tradespeople without group STD, and the 90-day elimination period replaces the 30-day statutory notice of claim.

133′. Kenji is a salaried employee who already has a group short-term disability (STD) plan through his employer that covers the first 120 days of disability. How can his advisor use this existing coverage to structure an individual long-term disability policy more affordably?

a. Select a longer elimination period of 120 days on the individual policy to lower the premium, since the group STD plan covers the initial waiting period.
b. Select a 30-day elimination period so he can collect full tax-free benefits from both policies simultaneously during the first 120 days.
c. Recommend a cancellable policy with a 2-year benefit period because employees with group STD do not need long-term protection.
d. Omit the written reason-why recommendation record because the employer's HR department already vetted the group STD plan.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

134. A software firm in Richmond has 40 employees and 5 years of stable extended health and dental claims experience. Its cash flow is healthy, and the founders want to lower long-term benefit costs and customize the drug formulary, but a sudden cluster of high-cost specialty drug claims would still strain a 40-person budget. Which funding recommendation best balances their goals and group size?

a. Keep a permanent non-refund accounting plan, because groups of only 40 employees are legally barred from sharing in any claims surplus with the insurer.
b. Use refund accounting (retention accounting) as a transitional step for a few years before evaluating a full move to an ASO arrangement with stop-loss coverage.
c. Switch immediately to an unhedged ASO plan without any stop-loss insurance so the firm keeps 100% of every surplus while carrying zero claims risk itself.
d. Replace the extended health plan with an Employee Assistance Plan (EAP) to cover specialty prescription drugs.

134′. A newly established bakery with fewer than 25 employees has tight monthly cash flow and zero claims history. The owner cannot afford any unexpected year-end benefit deficits. Which funding method should the group broker recommend?

a. Non-refund accounting (fully insured), where the insurer assumes all claims risk and retains any surplus.
b. Refund accounting (retention accounting), so the bakery shares claims deficits in exchange for a potential refund.
c. Administrative Services Only (ASO), so the bakery only pays a third-party administrator fee when claims occur.
d. Pure experience rating with 100% credibility so the bakery sets its own premium.

135. A mid-sized logistics company has 4 years of complete group claims history. The insurer's actuarial department assigns the group a credibility rating of 30%. Its experience rate is $45 per employee per month, while the manual rate for the industry is $60 per employee per month. What is the company's blended rate per employee per month?

a. $45.00, because 4 years of claims history qualifies the group for pure experience rating.
b. $49.50, calculated by applying 30% to the manual rate ($60) and 70% to the experience rate ($45).
c. $55.50, calculated by applying 30% to the experience rate ($45) and 70% to the manual rate ($60).
d. $60.00, because any credibility rating below 50% defaults entirely to the manual rate.

135′. Two employers are applying for group health coverage. Firm X is a newly formed start-up with fewer than 25 employees and no claims history. Firm Y is a large established employer with a low annual employee turnover rate of 5—10% and many years of claims data. How will the insurer assign credibility ratings when calculating their premiums?

a. Firm X receives high credibility because fewer than 25 employees are easier to track one by one, while Firm Y must rely entirely on manual rating instead.
b. Both firms receive a 30% credibility rating because all group plans use the same fixed blended formula.
c. Firm X is denied group coverage due to zero credibility, while Firm Y pays the manual rate of $60.
d. Firm X receives zero credibility and is priced entirely by manual rating (pooled experience), while Firm Y receives high credibility weighting its own experience rate.

136. Marcus participates in his employer's group long-term disability (LTD) plan, where the employer and employees each pay 50% of the premium. This year, Marcus goes on claim and receives $9,600 in LTD benefits. Since joining the plan, his cumulative employee premium contributions that have not yet been used to offset benefits total $3,600. Under ITA s.6(1)(f), how much of this year's LTD benefit must Marcus include in his taxable income?

a. $6,000, calculated by deducting his $3,600 of unused cumulative employee contributions from the $9,600 benefit received.
b. $4,800, calculated by multiplying the $9,600 benefit by the employer's 50% premium share.
c. $0, because employees pay half of the premium with after-tax dollars, making the entire benefit tax-free.
d. $9,600, because the $3,600 of employee contributions was already taxed as a benefit when paid.

136′. Following up on a group LTD plan where the employer and employee each pay 50% of the premiums: an employee received $9,600 in benefits last year and used all $3,600 of her accumulated employee contributions to reduce last year's taxable benefit to $6,000. If she remains disabled this year, pays no further premiums, and receives another $9,600, how much is taxable this year?

a. $4,800, because the 50% employer-paid ratio applies every calendar year.
b. $6,000, because the same $3,600 cumulative contribution deduction can be claimed again against each new year's benefit.
c. $9,600, because her unused cumulative employee contributions are now zero and cannot be deducted a second time.
d. $3,600, because taxable income is capped at the employee's historical contribution total.

137. Liam (born March 15) and his spouse Elena (born July 2) live together and each have group dental coverage through their respective employers. Their daughter incurs a $600 eligible dental expense. Liam's plan reimburses 80% with no deductible, while Elena's plan reimburses 100% with no deductible. How will the two plans co-ordinate this $600 claim?

a. Elena's plan pays first ($600) because its 100% reimbursement rate is higher than Liam's 80% rate.
b. Liam's plan pays $480 first, and Elena's plan pays $600 second, giving the family a $480 surplus.
c. Each plan pays half of the bill ($300 from Liam's plan and $300 from Elena's plan).
d. Liam's plan pays first ($480), and Elena's plan pays second ($120), leaving $0 out-of-pocket for the family.

137′. Hannah (born July 2) incurs a $600 dental bill for her own treatment. Her employer's group plan covers 80% of dental expenses with no deductible. Her husband Noah (born March 15) has a group plan that covers 100% of spouses' dental expenses with no deductible. How is Hannah's own $600 dental claim settled?

a. Noah's plan pays first ($600) because his March 15 birthday is earlier in the calendar year than Hannah's July 2 birthday.
b. Hannah's plan pays $480 first; Noah's plan then pays the lesser of $600 or the $120 balance, which is $120.
c. Hannah can choose to submit the claim only to Noah's plan so it pays the full $600 directly as primary payer.
d. Hannah's plan pays $480 and Noah's plan pays nothing because spousal plans only cover dependent children.

138. An employer wants its group short-term disability (STD) plan to qualify for the ESDC EI Premium Reduction Program. According to the exam benchmark rule and verified ESDC program rules, what minimum benefit criteria must the employer's STD plan satisfy?

a. Benefits equal to or better than EI sickness benefits: at least 15 weeks at 55% or more, up to the applicable EI weekly maximum.
b. It must provide at least 26 weeks of STD benefits at 70—75% of earnings because any 15-week plan is automatically disqualified.
c. It only needs to match the 1-week EI waiting period and pay a flat $60 per month.
d. It must be funded exclusively through an Administrative Services Only (ASO) structure with 25 or fewer employees.

138′. When answering an LLQP exam question that tests the maximum duration of federal Employment Insurance (EI) sickness benefits without specifying a number in the stem, which benchmark should the candidate be alert to, and how does it compare with current law?

a. The exam benchmark is 3 months, whereas current law provides 30—60 days.
b. The exam benchmark is 26 weeks at $638/week, whereas current law has since reduced the maximum to 15 weeks at $729/week.
c. 15 weeks (after a 1-week wait) at 55% up to $638/week on the exam; current law allows 26 weeks (up to $729/week in 2026).
d. Both the exam and current law set EI sickness benefits at 50—60% of earnings for 4 years.

139. An employer pays 100% of the premiums for a group benefit package that includes group term life insurance, accidental death and dismemberment (AD&D), and a private health services plan (PHSP) for extended health and dental. Under federal tax rules, how do the employer's premium contributions affect an employee's taxable income at the time the premiums are paid?

a. Employer-paid PHSP premiums are a taxable benefit, whereas group term life and AD&D premiums are tax-exempt.
b. Employer-paid group term life and flat AD&D premiums generally create a taxable benefit, while qualifying PHSP health and dental premiums generally do not.
c. All employer-paid premiums across all three benefits are non-taxable at the time of payment, and all claims paid to the employee are taxed as income.
d. The employee must include 50% of all employer-paid premiums in taxable income regardless of the benefit type.

139′. In a group benefit plan where the employer pays 100% of the premiums for group term life insurance, a qualifying PHSP (dental and extended health), and a group short-term disability (STD) income replacement plan, which benefit payment received by an employee or beneficiary is taxable as income?

a. The periodic STD income replacement benefits received by the disabled employee.
b. The principal death benefit paid under the group term life insurance policy.
c. The dental expense reimbursement paid under the qualifying PHSP.
d. None of the three benefit payments are taxable because the plan sponsor is the policyholder.

140. An employer switches its group benefit plan from one insurer to another. Several employees protest that they never signed the new contract and demand that the group broker personally adjudicate and pay their pending dental claims. How do group contract law and broker duties apply in this situation?

a. The switch is invalid without every employee's signature on the master contract, and the broker must pay the claims from agency funds.

b. Employees have no statutory rights at all under provincial law once an employer signs a group contract, and the broker carries no service or complaint obligations after the sale.

c. The employer and insurer are the contracting parties (members still have BC s.96 rights such as policy copies), and the insurer or TPA handles claims while the broker assists with service.

d. The broker must issue a request for quotation (RFQ) to ESDC so the government adjudicates the dental claims.

140′. During the initial design and quoting stage of a group benefit plan, what documents and information must the group broker collect from the employer before issuing a request for quotation (RFQ) to insurers?

a. Each employee's individual tax returns and cumulative unused LTD contribution history from previous, unrelated employers going back several years.

b. Group makeup (headcount, age/sex mix, turnover), the industry, an employee data sheet (salaries, classes, dependants), and current plan terms and claims if replacing.

c. Signed master contracts from each employee and their spouses' birth certificates for the birthday rule.

d. Only the employer's preferred 33% ASO discount rate, since group plans never need employee salary, occupational class or dependant data to be quoted.

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

Segregated Funds & Annuities

Items marked ′ are variants on the same point: do one when you miss the main question.

141. Elena invests a lump sum of $10,000 at a nominal annual return of 6% for 20 years, making no additional contributions or withdrawals. Compared with an account that pays only simple interest on the original principal at the same 6% rate for 20 years, approximately how much more will Elena accumulate through annual compounding?

a. Approximately $10,071 more
b. Approximately $12,000 more
c. Approximately $22,000 more
d. Approximately $32,071 more

141′. Victor places $10,000 into a long-term savings vehicle earning 6% compounded annually for 20 years with no subsequent deposits or withdrawals. What will be the approximate total future value of Victor's investment at the end of the 20-year period?

a. Approximately $22,000
b. Approximately $10,071
c. Approximately $32,071
d. Approximately $40,000

142. Nadia has already maximized her lifetime Tax-Free Savings Account (TFSA) contribution room by March of this year. In June, she withdraws $5,000 from her TFSA to pay for car repairs. In October of the same year, she receives a bonus and wants to re-contribute the $5,000 back into her TFSA immediately. What is the tax consequence if she makes this deposit in October?

a. No penalty applies because TFSA withdrawals immediately restore contribution room within the same calendar year.
b. The $5,000 deposit will be treated as an over-contribution subject to a penalty tax of 1% per month on the excess amount.
c. Only $3,000 will be penalized at 1% per month because TFSA rules provide a $2,000 lifetime over-contribution buffer.
d. The June withdrawal of $5,000 will retroactively become taxable income on her current-year tax return.

142′. Liam had zero remaining contribution room in his TFSA after making his annual deposit in January. In August, he withdrew $7,000 from his TFSA for a family trip. What is the earliest date Liam can re-contribute that $7,000 withdrawn amount without triggering a monthly over-contribution penalty?

a. January 1 of the following calendar year
b. Immediately after the withdrawal settles in August of the current year
c. March 1 of the following year, matching the RRSP contribution deadline
d. Never, because TFSA withdrawals permanently eliminate contribution room just like RRSP withdrawals

143. Daniel had no unused RRSP contribution room carried forward and belongs to no employer pension plan. He earned $40,000 in the previous year and received a promotion on January 1 of the current year that raised his annual earned income to $65,000. Based on the standard 18% formula, how much new RRSP contribution room did Daniel generate for the current year, and what is the latest age by which his own RRSP must mature?

a. $11,700 in new room; must mature by the end of the year he turns 71.
b. $7,200 in new room; must mature by the end of the year he turns 65.
c. $7,200 in new room; must mature by the end of the year he turns 71.
d. $11,700 in new room; must mature by the end of the year he turns 59.

143′. Margaret turns 71 in November of this year and still holds a substantial balance in her individual RRSP. Which of the following actions is a valid maturity option she must complete by December 31 of this year to avoid having the entire balance deregistered and taxed in one lump sum?

a. Transfer the RRSP balance directly into her Tax-Free Savings Account (TFSA) on a tax-deferred basis.
b. Convert the RRSP into a Registered Retirement Income Fund (RRIF) or purchase an eligible annuity.
c. Keep the RRSP open and continue making tax-deductible contributions until she stops working at age 75.
d. Roll the RRSP balance directly into a Registered Education Savings Plan (RESP) without tax consequences.

144. Hannah holds a $60,000 Guaranteed Investment Certificate (GIC) at a member bank, a $90,000 stock portfolio at an investment dealer, and an $80,000 segregated fund contract with a life insurance company. She asks her agent who regulates the sale of her segregated fund contract and which protection organization covers her segregated fund if the issuer becomes insolvent. Which response is correct?

a. Regulated by the securities self-regulatory organization (IIROC/MFDA, now CIRO) and protected against insolvency by CIPF.
b. Regulated by the provincial insurance regulator and protected against insurer insolvency by Assuris.
c. Regulated by the provincial insurance regulator and protected against both insolvency and market declines by CDIC.
d. Regulated by the federal banking regulator and protected against market losses of up to 20% by Assuris.

144′. Arthur holds a $100,000 equity mutual fund in an account with a registered mutual fund dealer. Due to a broad stock market downturn, the value of his mutual fund drops by 20% to $80,000, while the dealer remains financially solvent. How much compensation will Arthur receive from the investor protection fund (CIPF, or IPC in the exam manual)?

a. $20,000, because the loss is well below the $1,000,000 maximum coverage limit.
b. $15,000, because investor protection funds guarantee at least 75% of the original deposit during market crashes.
c. $100,000, provided Arthur transfers the mutual fund to a CDIC-member bank within 30 days.
d. $0, because investor protection funds only cover client property if the member firm becomes insolvent, not market value losses.

145. A married couple in Richmond, each earning $65,000 annually, plans to buy their first home in three years. They meet all first-time home buyer eligibility rules, currently hold $15,000 in their TFSAs, and have almost no RRSP savings. When comparing current registered account options for their upcoming home purchase, which statement accurately describes the rules of the First Home Savings Account (FHSA), the RRSP Home Buyers' Plan (HBP), and the TFSA?

a. FHSA contributions are non-deductible like a TFSA, and qualifying withdrawals must be repaid over 15 years like the RRSP HBP.
b. FHSA contributions are deductible and qualifying home withdrawals are tax-free with no repayment, while HBP withdrawals must be repaid or become taxable income.
c. A buyer must choose only one account among the FHSA, RRSP HBP, and TFSA because federal rules prohibit combining them for the same home purchase.
d. Opening a new RRSP specifically for a three-year home purchase horizon is always superior to an FHSA because RRSPs have no annual contribution cap.

145′. A parent contributes to a Registered Education Savings Plan (RESP) for a child who will attend university, while an aunt contributes to a Registered Disability Savings Plan (RDSP) for a relative under age 59 who qualifies for the Disability Tax Credit (DTC). How are contributions and future withdrawals of government grants and investment growth taxed across both plans?

a. Contributions to both plans are tax–deductible for the contributor, and all withdrawals including grants are completely tax–free.
b. Contributions are not tax–deductible, and when withdrawals occur, the entire amount including returned principal is taxed in the contributor's hands.
c. Contributions are tax–deductible up to $50,000 per year for an RESP and $200,000 per year for an RDSP, with grants taxed annually as they accrue.
d. Contributions are after–tax and not deductible; on withdrawal, contributions come back tax–free while grants and investment growth are taxed to the beneficiary.

146. During an initial Know Your Client (KYC) meeting, an agent reviews a client's net worth statement showing $600,000 in total assets and almost no liabilities, with 100% of the assets held in savings accounts and locked–in GICs. The client needs $80,000 in two years to fund a business obligation but says he feels comfortable taking big market swings to chase higher returns. How should the agent evaluate this client's situation?

a. Conclude that the client has high risk capacity and needs no life insurance or conservative reserves because his $600,000 net worth is substantial.
b. Invest the $80,000 in a high–volatility equity fund because the client's stated risk tolerance overrides his two–year time horizon.
c. Record tolerance, capacity and perception separately, keep the two–year money in low–volatility liquid assets, and collect cash flow and goal details before recommending.
d. Place the $80,000 into an immediate life annuity because annuities offer the highest liquidity for a two–year obligation.

146′. A client has a non–registered portfolio and wants to compare how different types of investment income and liquidity work before choosing between bonds, common stocks, and cash equivalents. Under current Canadian tax rules, which statement accurately describes the taxation and risk characteristics of these assets in a non–registered account?

a. Interest income is 100% taxable at the marginal rate, capital gains have a 50% inclusion rate, and existing bond prices fall when market interest rates rise.
b. Capital gains are taxed at a 66.67% (two–thirds) inclusion rate on the first dollar earned, while interest income enjoys a federal tax credit.
c. Diversifying across multiple stocks completely eliminates systematic market risk, and foreign dividends qualify for the Canadian eligible dividend tax credit.
d. Net capital losses realized inside a TFSA or RRSP can be carried back 3 years to offset taxable capital gains in a non–registered account.

147. David, age 55, lives in Surrey and plans to retire in 10 years at age 65. His current annual living expenses are $80,000. He expects inflation to average 3% per year over the next 10 years, and he estimates that his living expenses in his first year of retirement will drop by 40% (meaning he will need 60% of his pre-retirement standard of living). Using the compound growth factor (1.03)^10 ≈ 1.344, approximately how much annual spending will David need in his first year of retirement at age 65?

a. Approximately $48,000
b. Approximately $43,008
c. Approximately $67,520
d. Approximately $64,512

147′. While calculating David's retirement income gap in 2026, his agent notes that David's annual pensionable earnings are $85,000, which exceeds the first-tier Year's Maximum Pensionable Earnings (YMPE of $74,600) up to the second-tier ceiling (YAMPE of $85,000). How does the exam reference manual's treatment of the Canada Pension Plan (CPP) differ from current 2026 rules for a client in David's income bracket?

a. The exam covers only the first tier (YMPE, $3,500 exemption); 2026 rules add a second tier (CPP2 up to the $85,000 YAMPE, 4% on the $10,400 band).
b. The exam manual includes both YMPE and YAMPE, whereas current 2026 rules abolished the $3,500 basic exemption for all workers.
c. The exam manual states that CPP contributions are optional for employees earning above the YMPE, whereas current rules deduct 18% up to $33,810.
d. Both the exam manual and current 2026 rules cap all CPP pensionable earnings at $65,000 with no second earnings ceiling.

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

Segregated Funds & Annuities

Items marked ′ are variants on the same point: do one when you miss the main question.

148. Victor, a business owner in British Columbia, invests $300,000 in a non-registered segregated fund contract (IVIC) where he is both the policy owner and the annuitant. He wants to know how naming either his close friend Daniel or his spouse Elena as revocable beneficiary affects probate fees and protection against his creditors during his lifetime.

a. Either name lets the death benefit bypass probate, but only naming his spouse Elena gives lifetime creditor protection under s.65(2) of the BC Insurance Act.

b. Neither designation provides creditor protection because a beneficiary designation in British Columbia must always be irrevocable to shield segregated funds from creditors.

c. Naming his friend Daniel qualifies for both probate bypass and statutory creditor protection because any named non-estate beneficiary shields an IVIC from creditors.

d. Naming Elena saves only the $208 general court application fee, because BC probate fees of $6 and $14 per $1,000 still apply to segregated fund death benefits paid to a spouse.

148′. Grace owns a sole proprietorship in BC and holds a non-registered segregated fund contract with a current value of $300,000, which is her only asset besides a joint bank account. If she changes her revocable beneficiary from her estate to her adult daughter Chloe, what is the legal and probate cost effect?

a. The contract remains exposed to Grace's business creditors unless Chloe is named as an irrevocable beneficiary, though it avoids approximately $3,650 in tiered probate fees.

b. It is shielded from Grace's creditors under s.65(2) and bypasses probate, saving about $3,650 in tiered fees plus the court application fee ($208 on the exam).

c. The contract bypasses probate and saves $14 per $1,000 on the entire $300,000 balance, but adult daughters do not qualify as family beneficiaries under BC law.

d. The contract is protected from creditors, but probate fees of $3,650 still apply unless the segregated fund is held inside a registered RRSP or RRIF.

149. Seven years ago, Owen deposited $50,000 into a 10-year segregated fund contract offering a 75% maturity guarantee and a 75% death benefit guarantee. Today, in Year 7, the market value of his units has fallen to $32,000, and Owen surrenders the entire contract to pay for an urgent home repair. How much will Owen receive before any applicable redemption charges?

a. $37,500, because the 75% guarantee ensures he never receives less than $37,500 upon full surrender.

b. $32,000, because maturity and death benefit guarantees apply only at contract maturity or upon the annuitant's death, not on early surrender.

c. $32,000 today, plus a top-up payment to $37,500 that the insurer will mail to him automatically on the original 10-year maturity date.

d. $50,000, because segregated funds are Individual Variable Insurance Contracts that guarantee full principal return after five years.

149′. Ten years ago, Owen deposited $50,000 into a 10-year segregated fund contract with a 75% maturity guarantee. Today is the exact 10-year maturity date, and the market value of the contract is $30,000. Owen has not contacted the insurer to file a claim. What happens to his contract today?

a. He receives nothing above $30,000 unless he submits a written maturity claim form before the end of the business day.

b. The contract is valued at $50,000 because the insurer must restore 100% of the initial deposit at the 10-year mark.

c. The maturity guarantee settles automatically at $37,500, which includes a $7,500 top-up funded from the insurer's general assets.

d. The $7,500 shortfall is paid by Assuris because the underlying investment fund failed to meet its 75% target.

150. Hannah purchased a segregated fund contract with a $40,000 deposit, selecting a 75%/100% guarantee structure. Her husband Liam is the annuitant, and Hannah is the named beneficiary. In Year 6 of the contract, Liam dies when the market value of the units is $36,500. How much will Hannah receive as the death benefit?

a. $36,500, because Liam died in Year 6 before completing the mandatory 10-year minimum waiting period for guarantees.

b. $30,000, because the first number in 75%/100% applies to death before maturity, which is lower than the $36,500 market value.

c. $40,000, consisting of the $36,500 market value plus a $3,500 top-up triggered under the 100% death benefit guarantee.

d. $40,000, but only after the estate completes probate and pays the court application fee.

150′. Hannah purchased a segregated fund contract with a $40,000 deposit and a 75%/100% guarantee structure, naming her husband Liam as annuitant and herself as beneficiary. When Liam dies in Year 6, the market value of the contract has grown to $52,000. How much does Hannah receive?

a. $52,000, because the market value exceeds the $40,000 death benefit guarantee, so no top-up is required.
b. $40,000, because a 100% death benefit guarantee caps the payout at 100% of the initial deposit if death occurs before Year 10.
c. $30,000, because the 75% guarantee ratio applies to the $40,000 initial deposit when death occurs prior to the 10-year maturity date.
d. Both the $52,000 market value and the $40,000 insurance guarantee combined, because death occurred while the contract was in force.

151. Five years ago, Sophia deposited $60,000 into a 10-year segregated fund contract with a 75% maturity guarantee (original maturity at age 50). Today, at age 45, the market value of her contract rises to $90,000 and she exercises a maturity guarantee reset. What are her new maturity guarantee amount and her new maturity age?

a. Her maturity guarantee remains $45,000 until age 50, and then increases to $67,500 without extending the contract maturity date.
b. Her maturity guarantee increases to $90,000, and her maturity date is extended by 10 years to age 55.
c. Her maturity guarantee increases to $67,500, and her contract maturity date remains at age 50 because five years have already elapsed.
d. Her maturity guarantee increases from $45,000 to $67,500, and her new maturity date is extended to age 55 (10 years from the reset date).

151′. Sophia, age 45, holds a 10-year segregated fund contract (75% maturity guarantee) purchased 5 years ago with $60,000, now worth $90,000. She plans to withdraw the entire balance in 5 years at age 50 to buy a cottage and cannot tolerate market volatility beyond age 50. How should her agent evaluate a maturity reset today?

a. A reset needs reassessment and likely does not fit, since moving maturity to age 55 turns her age-50 withdrawal into an early surrender at market value.
b. She should reset immediately because locking in the $67,500 guarantee ensures she will receive at least $67,500 when she withdraws the funds at age 50.
c. She should reset because an agent can guarantee that equity markets will continue rising over the next five years.
d. She cannot reset at age 45 because non-registered contracts prohibit any reset before the original 10-year term expires.

152. Lucas holds a segregated fund contract with a promised maturity guarantee. If the issuing life insurance company becomes insolvent, what is the protection limit for segregated fund guarantees under the 2022 LLQP exam standard for Assuris?

a. $60,000 or 85% of the promised guarantee, whichever is higher, but never more than the original benefit.
b. Up to $100,000 or 90% of the promised guarantee, whichever is higher, with no further limit applied.
c. Up to $200,000 or 85% of the promised guarantee, whichever is higher, for every type of contract.
d. A monthly income cap of $2,000 or 85% of what was promised, whichever is greater.

152′. Lucas holds a segregated fund contract with an original guarantee of $50,000. If the issuing life insurance company becomes insolvent, how much of his $50,000 guarantee is retained under the 2022 LLQP exam standard for Assuris?

a. $37,500, because Assuris applies a 75% ratio to the $50,000 guarantee when a life insurer fails.
b. $60,000, because Assuris raises any guarantee below the threshold up to the $60,000 dollar threshold.
c. $100,000, because Assuris automatically tops up small contracts to the maximum protection threshold.
d. $50,000, because a guarantee below the $60,000 exam threshold is retained in full.

153. At the beginning of Year 1, Kevin opened a 10-year segregated fund contract with a 75% maturity guarantee (deposit date-based) and deposited $10,000. He made two additional deposits of $10,000 each at the beginning of Year 2 and Year 3. When does his second $10,000 deposit mature, and what is the cumulative maturity guarantee that has reached maturity by the end of Year 11?

a. The second deposit matures at the end of Year 10 with the first deposit, bringing the total matured guarantee to $22,500 at Year 10.
b. The second deposit matures at the end of Year 11 (10 years from its deposit date), bringing the cumulative matured guarantee to $15,000 by the end of Year 11.
c. The second deposit matures at the end of Year 11, bringing the cumulative matured guarantee to $30,000 because recurring deposits earn a 100% maturity guarantee on all three deposits.
d. Adding the second deposit resets the entire contract's 10-year clock, so neither deposit matures until the end of Year 12.

153′. Kevin holds a segregated fund contract and tells his agent he wants to withdraw part of his money in Year 4, assuming that because the contract is still six years away from its 10-year maturity date, a partial withdrawal now will have no effect on his future maturity guarantee. What must the agent explain?

a. A partial withdrawal has no effect on the guarantee base as long as Kevin redeposits the same amount before the 10-year maturity date.
b. A partial withdrawal reduces the maturity guarantee percentage from 75% to 50%, while leaving the original principal base unchanged.
c. It permanently cuts the principal base for the guarantee in proportion to the withdrawal, although the guarantee percentage itself does not change.
d. A partial withdrawal can be made without any guarantee reduction if the client gives verbal instructions rather than written instructions.

154. Evelyn, age 65, is retiring and fears outliving her savings if she lives past age 90 and market downturns deplete her portfolio. When her agent completes her investor profile first and then evaluates segregated fund features, which rider specifically transfers this longevity risk to the insurer by guaranteeing income for life even if the contract's market value drops to zero?

a. A standard 100% death benefit guarantee, because it pays the full initial deposit to Evelyn once she reaches age 90.
b. A front-end load (FEL) sales charge option, which eliminates the management expense ratio (MER) during retirement.
c. A Guaranteed Minimum Withdrawal Benefit (GMWB), because a GMWB always guarantees lifetime withdrawal payments without any fixed term limit at all.
d. A Guaranteed Lifetime Withdrawal Benefit (GLWB) rider, which for an added fee keeps paying withdrawals for life even after the fund value is used up.

154′. An agent meets a prospective client who asks to buy a specific global equity segregated fund immediately. Under the Fair Treatment of Customers (FTC) principle and suitability rules, what is the correct sequence of steps the agent must follow, and how are underlying segregated fund investments categorized?

a. Complete the investor profile (objectives, risk tolerance, time horizon) first, then match a fund from the five CIFSC asset classes: cash, fixed income, equity, commodities, other.
b. The agent should select the fund with the highest commission first and then complete the investor profile to match that fund's risk rating.
c. The agent can skip the investor profile because all segregated funds carry a 75% maturity guarantee that eliminates principal risk during the contract term.
d. The agent must obtain approval from CIRO before recommending any of the 14 CIFSC segregated fund categories.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

155. Marcus transfers a single lump sum of $120,000 from his savings into an annuity contract today. Under the terms of the contract, the insurer will hold and credit interest on the funds for 5 years, and monthly income payments to Marcus will begin at the end of year 5. How is this annuity classified?

a. An immediate annuity, because it was funded with a single lump-sum deposit rather than periodic contributions.

b. A deferred annuity, because income payments begin after an accumulation phase rather than within the first payment period.

c. An immediate term-certain annuity with a 5-year guaranteed period.

d. A prescribed immediate annuity, because only periodic-deposit contracts can be deferred.

155′. Elena wants her annuity income to start next month. She asks her advisor if she can set up an immediate annuity by making five annual deposits over the next 5 years while collecting monthly annuity payments right away. How should the advisor respond?

a. Explain that an immediate annuity must be purchased with a lump sum and cannot accept ongoing deposits once in the payout phase.

b. Confirm that any annuity can accept periodic deposits during the payout phase as long as it is non-registered.

c. Explain that making periodic deposits automatically makes the contract an immediate annuity if the first payment starts within one year.

d. Suggest adding a 5-year guaranteed period so she can spread her premium deposits across the guaranteed years.

156. Liam holds a payout life annuity that promises him a monthly income of $5,000. If the issuing life insurance company becomes insolvent, how much of Liam's monthly benefit is protected by Assuris if the question tells you to use the pre-May 2023 figures printed in the exam syllabus?

a. $2,000 per month, because $2,000 is the absolute maximum monthly cap.

b. $4,500 per month, calculated as 90% of the promised $5,000 monthly payment.

c. $4,250 per month, since 85% of the promised payment is larger than the old $2,000 monthly floor.

d. $5,000 per month under the 2022 exam rule, because benefits up to $100,000 per year are 100% covered.

156′. Suppose an updated practice question explicitly instructs you to apply current Assuris protection standards (post–May 2023 rules) rather than the 2022 exam figures. If an insurer fails while owing a client a promised payout annuity of $5,000 per month, what monthly amount is protected?

a. $4,250 per month, based on the 85% coinsurance formula.
b. $4,500 per month, because current protection is capped at 90% of the promise once payments reach $5,000.
c. $2,000 per month, because the base dollar floor was unchanged.
d. $5,000 per month, since current cover is the greater of $5,000 a month or 90% of the promised payment.

157. Hannah purchases an immediate non–registered annuity with $120,000. The insurer confirms it qualifies as a prescribed annuity and pays $700 per month, of which $500 is return of principal and $200 is taxable interest. How much taxable annuity income must Hannah report for the full calendar year, and how does this compare with a non–prescribed (accrual) annuity?

a. She reports $2,400 per year, with a level taxable portion across the payout period under the prescribed rules.
b. She reports the full $700 per month as taxable income, because all annuity payments are fully taxable like registered annuities.
c. She reports $6,000 per year initially, and the law guarantees her lifetime total tax paid will be identical to an accrual annuity.
d. She reports no taxable income until her entire $120,000 principal has been returned to her.

157′. Instead of starting income immediately, a client holds a non–registered deferred annuity for a 5–year accumulation period before annuity payments begin. How is this contract taxed during the 5–year accumulation phase and when the payout phase starts?

a. It is taxed as a prescribed annuity during the 5–year accumulation phase and switches to accrual taxation once payments start.
b. Accrued interest is reported annually during the 5–year accumulation period, and the contract is permanently barred from ever becoming a prescribed annuity.
c. Accrued income is taxed annually during the 5–year accumulation period, and eligibility for prescribed annuity taxation is re–evaluated in the year payments begin.
d. No tax is reported during the 5–year accumulation period unless cash withdrawals are made.

158. Arthur and his spouse, Beatrice, are the two annuitants on a joint and last survivor life annuity with a 10-year guaranteed period. Their adult son, Colin, is the named beneficiary. If Arthur dies after 5 years of payments while Beatrice is still alive, what happens to the annuity payments?

a. Colin immediately receives the remaining 5 years of guaranteed payments as a lump sum or installments.

b. Beatrice continues receiving payments as the sole surviving annuitant, and a fresh 10-year guaranteed period restarts for her.

c. Half of the remaining guaranteed payments go to Colin immediately, and the other half continues to Beatrice.

d. Beatrice carries on as sole annuitant; Colin gets a guaranteed balance only if Beatrice also dies within the original 10 years.

158′. Following up on a joint and last survivor annuity with a 10-year guaranteed period: suppose the first spouse dies in year 5, and the surviving spouse dies in year 12. How much guaranteed period death benefit is payable to the named beneficiary upon the second spouse's death?

a. 3 years of guaranteed payments, because a new 10-year guarantee started for the surviving spouse in year 5.

b. Nothing, because the original 10-year guaranteed period ran out before the second annuitant died.

c. 5 years of payments, representing the unused portion from when the first spouse died in year 5.

d. 10 full years of payments, because the beneficiary's guarantee is separate from payments made to the spouses.

159. A client wants to transfer a portion of her RRIF into an Advanced Life Deferred Annuity (ALDA) to protect against longevity risk late in life. According to the LLQP exam rules (and noting the 2026 CRA dollar update), what are the percentage limit per source plan, the lifetime dollar cap, and the latest age by which payments must begin?

a. Up to 25% of each source plan, an exam limit of $150,000 ($180,000 in 2026), with payments starting by the end of the year the annuitant turns 85.

b. Up to 50% of a source plan, a lifetime cap of $100,000, and payments starting no later than the end of the year the annuitant turns 71.

c. Up to 25% of a source plan, an exam limit of $150,000, and payments extending as a term-certain annuity to age 90.

d. Up to 100% of a source plan up to $150,000, provided the plan has at least 10 participating members.

159′. An advisor compares an Advanced Life Deferred Annuity (ALDA) with a Variable Payment Life Annuity (VPLA) under the LLQP exam rules. How does the latest age for starting payments under a VPLA differ from an ALDA?

a. Both a VPLA and an ALDA let the member put off the first payment until the year-end in which they reach age 85.
b. On the exam a VPLA must start paying by 71 (now the later of 71 or the year the right is acquired), but an ALDA can wait to 85.
c. VPLA payments must begin within one year of turning age 60, whereas ALDA payments may not begin before age 90.
d. VPLA has no maximum starting age as long as at least 10 members remain in the pool.

160. David, age 68, and his wife, Karen, age 65, are purchasing a joint and last survivor annuity with a 50% survivor benefit. Having already gifted their home to their financially independent daughter, they tell their agent they have zero need to leave a cash estate and want the highest possible monthly income while either of them is alive. How should the agent structure the guaranteed period?

a. Add a 20-year guaranteed period so their monthly income is locked in against market interest rate drops.
b. Leave the guaranteed period out, since it only protects a beneficiary after both deaths and lowers their monthly income.
c. Add a 10-year guaranteed period, because joint annuities are legally required to carry at least a 10-year guarantee.
d. Replace the joint life annuity with a 20-year term-certain annuity so payments are maximized for a fixed period.

160′. An agent reviews two quotes for the same 65-year-old client using the same lump-sum premium on the same day: Quote 1 is a single life annuity with no guaranteed period, and Quote 2 is a single life annuity with a 20-year guaranteed period. Which quote provides the higher monthly income and why?

a. Quote 2 provides a higher monthly income, because the 20-year guarantee rewards the client for committing funds long term.
b. Both quotes pay the exact same monthly amount, because the client's age and initial premium are identical.
c. Quote 1 pays more, because a guaranteed period makes the insurer price in possible death payments, which lowers each payment.
d. Quote 1 provides a higher monthly income only during the first 20 years, after which Quote 2 steps up.

161. Walter, age 60, wants to leave a $500,000 tax-free estate to his two daughters while generating net spendable retirement income from his capital today. His advisor proposes an insured annuity strategy combining a $500,000 Term-100 life insurance policy (costing $1,000/month) and a single life annuity (yielding $1,300/month after tax). What is the mandatory execution sequence for setting up this strategy?

a. Purchase the single life annuity first so the $1,300 monthly cash flow is already in place to pay the first insurance premium.
b. Submit both applications simultaneously with a binding stipulation that the life insurance policy requires no medical underwriting.
c. Complete underwriting and have the permanent life insurance policy approved and in force first, and only then purchase the life annuity.
d. Buy a 20-year guaranteed life annuity first and name the two daughters as irrevocable annuity beneficiaries instead of buying life insurance.

161′. Once an insured annuity strategy is properly in force (with a permanent life insurance policy and a single life annuity with no guaranteed period), what happens financially when the insured annuitant dies?

a. Both the annuity payments and the life insurance death benefit are paid to the beneficiaries.
b. The annuity stops with no further payments, premiums stop, and the tax-free life insurance benefit goes to the named beneficiaries.
c. The insurer deducts all annuity payments ever made from the life insurance face amount before paying the beneficiaries.
d. The life insurance death benefit is taxed as prescribed annuity interest in the hands of the beneficiaries.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

162. An individual is the sole income earner for his household, holds emergency savings covering only 3 months of expenses, and must pay for his child's university tuition in 3 years. During the KYC interview, he insists on putting all of his savings into a high-risk equity segregated fund, stating that he can easily handle a 20% market drop if it means higher long-term returns. How should the agent proceed?

a. Follow the client's explicit instruction and allocate the funds to the equity segregated fund after having him sign a risk waiver.
b. Bind the advice to his low financial risk capacity, separate the 3-year tuition money from long-term funds, and record both his high tolerance and low capacity.
c. Place the 3-year tuition fund into the equity segregated fund because the 75% or 100% maturity guarantee protects his principal after 3 years.
d. Alter the client's KYC interview notes to record a low risk tolerance so that the paperwork matches a conservative recommendation.

162′. A retired widower relies solely on CPP, OAS, and a small pension to cover his monthly living costs, and his entire liquid savings consist of $180,000 in maturing GICs that he may need to draw on at any time. After attending a seminar, he asks his agent to transfer the full $180,000 into a 100% global equity segregated fund because he wants higher returns and believes the contract guarantee makes it just as safe as a GIC. What should the agent do?

a. Process the transfer into the global equity segregated fund because the death and maturity guarantees eliminate market risk during interim withdrawals.
b. Execute the trade as requested because respecting the client's autonomy is the primary requirement under Fair Treatment of Customers (FTC).
c. Put half of the $180,000 into the global equity segregated fund as a compromise between his high return expectations and his limited income.
d. Treat his low financial risk capacity as the hard limit, explain that guarantees apply only at maturity or death, and suggest a conservative option such as renewed GICs.

163. An agent is calculating government pension contributions as part of a retirement income needs analysis for an employee earning $90,000 per year. Under the standard LLQP exam model, how are Canada Pension Plan (CPP) contributions structured, and what is the annual basic exemption amount?

a. Contributions apply to earnings above the $3,500 basic exemption, up to one ceiling called the Yearly Maximum Pensionable Earnings.
b. Contributions begin from the first dollar of earned income with no basic exemption and continue up to the $90,000 salary level.
c. Contributions apply only to earnings above $74,600 at a flat rate of 18% up to the RRSP annual dollar limit of $33,810.
d. Contributions are waived whenever an employee also participates in a Tax-Free Savings Account (TFSA) with a $7,000 annual limit.

163′. In 2026, a salaried professional in British Columbia earns $90,000 and asks her agent how her Canada Pension Plan (CPP) contributions are calculated in real practice today compared with the older single-tier exam formula. Which statement accurately describes the 2026 two-tier CPP structure?

a. The $3,500 basic exemption was abolished in 2026, so Tier 1 contributions now apply to all earnings up to the $85,000 YAMPE.
b. Tier 2 (CPP2) applies an 18% contribution rate to all earnings above $85,000 with an over-contribution buffer of $2,000.
c. Tier 1 runs from $3,500 to the $74,600 YMPE; Tier 2 adds 4% each on the $10,400 band up to the $85,000 YAMPE, capped at $416 each.
d. Tier 2 contributions are voluntary and can be redirected into a First Home Savings Account (FHSA) up to $8,000 per year.

164. An elderly investor loses mental capacity, and his son, acting as attorney under a valid Power of Attorney (POA) for property, contacts the insurance agent. The son wishes to rebalance the fund allocations inside his father's existing segregated fund contract (IVIC) and also replace the currently named beneficiary with himself, without a court order. How should the agent respond?

a. Allow both requests immediately, because a Power of Attorney for property gives the attorney full ownership rights over the grantor's insurance contracts.
b. Refuse both requests, because an attorney for property is prohibited from switching or selling investments inside a segregated fund contract.
c. An attorney may switch the investments but generally cannot change an existing beneficiary; in BC that change needs court authorization under s.20.
d. Permit the beneficiary change without court authorization as long as the segregated fund contract is free of Deferred Sales Charges (DSC).

164′. In British Columbia, an enduring attorney acting under a Power of Attorney for property is moving an incapable grantor's maturing segregated fund into a replacement contract and wants to know the legal rules governing beneficiary designations under section 20 of the BC Power of Attorney Act. Which statement is correct?

a. The attorney may carry over the beneficiary the adult chose while capable when replacing a similar instrument, but changing one needs a court order and a new designation is limited to the estate.
b. Because British Columbia is noted as an exception in the exam manual, an attorney in BC has unrestricted authority to name any family member as a new beneficiary without court involvement.
c. An attorney in BC can change the beneficiary to anyone if the grantor verbally expressed that wish during a market downturn of 20%.
d. An attorney can never sign an application to renew or replace a maturing contract in BC, even if the beneficiary remains the grantor's estate.

165. An agent is reviewing two clients on the same day: Client X is 28 years old and is saving inside a TFSA to pay for a wedding in 2 years; Client Y is 68 years old, receives a stable defined benefit pension that more than covers her living costs, and is investing a separate pool of capital strictly for her grandchild's university education in 20 years. How should the agent determine the time horizon for each client's investment?

a. Client X has a long time horizon of over 35 years because she is 28, while Client Y has a short time horizon because she is already 68.
b. Both clients have a short time horizon because TFSA and education savings accounts must be liquidated within 3 years.
c. Both clients have a long time horizon because every investor profile is determined solely by the client's life expectancy.
d. Client X has a short 2–year horizon tied to the wedding, while Client Y has a long 20–year horizon tied to when the education money is needed.

165′. A 28-year-old professional puts her annual $7,000 TFSA contribution into a money market fund, telling her agent, 'I am still young, so I should keep everything ultra-safe until I am older.' During the KYC needs analysis, the agent discovers that this money is earmarked exclusively for her retirement in 35 years, while she also holds a separate savings account for a vacation next year. What should the agent conclude about her time horizon and profile?

a. Both the retirement TFSA and the vacation savings must share the same short time horizon because they belong to the same 28-year-old investor.
b. Her TFSA retirement money has a long 35-year horizon set by its goal, while the vacation fund has a short horizon and needs its own profile.
c. Because she is 28 years old, even her next-year vacation fund has a 35-year time horizon and should be invested in high-risk equity funds.
d. Money market segregated funds carry a government deposit guarantee identical to a bank deposit, making time horizon irrelevant.

166. An agent is compiling a net worth statement for an older homeowner who recently took out a reverse mortgage to supplement his cash flow, and who also carries an investment loan and high-interest credit card debt. How must the agent treat the reverse mortgage and the other debts during the KYC financial review?

a. Record the reverse mortgage advance as a tax-free asset that increases the estate value, and evaluate only the credit card debt because investment loans are risk-free good debt.
b. Record the reverse mortgage as a liability repaid on death or sale, which erodes the estate, and check that both good and bad debts can be paid on time.
c. Exclude the reverse mortgage from the net worth statement entirely because no monthly payments are required while the homeowner lives in the property.
d. Classify credit card balances as good debt if used for family travel, and deduct the reverse mortgage from the client's Pension Adjustment (PA).

166′. During a financial review, a client asks his agent which documents should be used to accurately verify his available RRSP deduction limit and his remaining TFSA contribution room for 2026, and whether his home equity line of credit (HELOC) and mortgage can be left off the risk review since they are 'good debt.' What is the correct explanation?

a. Use the NOA for the RRSP limit, rebuild TFSA room from actual records at every institution because CRA data lag, and still test repayment of the mortgage and HELOC.
b. Assume the client currently has exactly $109,000 of available TFSA room in 2026 without checking past transactions, and ignore the mortgage because real estate always appreciates.
c. Use the client's utility bills to verify his RRSP deduction limit, and treat his HELOC balance as a liquid asset on the net worth statement.
d. Rely solely on the CRA online portal for real-time TFSA transactions made earlier the same month, and classify any reverse mortgage on the property as tax-free income.

167. Five years ago, a 50–year–old employed client completed a thorough investor profile and was placed into a medium–risk balanced segregated fund. Eighteen months ago, she went through a divorce that cut her net worth in half and took early retirement, changing her income structure, but she never contacted her agent to update her file. When a sharp market correction occurs today, how is the agent's obligation assessed?

a. Suitability is ongoing: divorce and early retirement call for reassessment, and the agent cannot read her silence as consent without a documented review process.
b. The agent has zero responsibility after the initial application date because an investor profile remains legally valid for the entire maturity term of the segregated fund.
c. Only a change in the segregated fund's management expense ratio (MER) triggers a suitability review, whereas changes in the client's personal or financial life are the client's sole responsibility.
d. Because the original fund was a balanced segregated fund rather than a 100% equity fund, no reassessment is ever required regardless of changes in net worth or income.

167′. Eighteen months after setting up a 75/100 balanced segregated fund for her retirement goal (originally planned for 13 years away) and a GIC for her child's tuition, a teacher takes early retirement and begins drawing her employer pension. Her agent conducts a formal review. Which elements must the agent include in the review documentation to serve as proper compliance evidence?

a. Only a new sales illustration showing the trailing commission rate, with no need to revisit her time horizon or obtain any signed confirmation.
b. A note stating that since her child's tuition GIC has not changed, her retirement segregated fund automatically requires no review.
c. A verbal reassurance given over the phone with no written record, so that the file stays simple if the Insurance Council of BC ever asks.
d. The trigger and date, the items reviewed such as new pension income and the shorter horizon, the conclusion such as cutting equity, and her signed date.

168. Two segregated fund products both meet a client's general time horizon, but Fund X pays a significantly higher sales commission and trailing fee to the agent while carrying higher volatility than the client's investor profile allows. Which regulatory principle specifically governs whether this single product recommendation matches this specific client's profile, and how must commission be treated?

a. The Fair Treatment of Customers (FTC) principle exclusively governs single-product matching and permits higher-commission recommendations if disclosed after the sale.
b. The Know Your Client (KYC) rule requires choosing the fund with the highest trailing fee because higher fees indicate stronger maturity guarantees.
c. The suitability principle governs whether this one recommendation fits the client's objectives, constraints and risk profile, and commissions must never sway it.
d. The Pension Adjustment (PA) principle governs product selection and allows commission to break a tie between two segregated funds.

168′. A compliance officer is training new licensing candidates on the relationship between Know Your Client (KYC), the suitability principle, the reason-why letter, and Fair Treatment of Customers (FTC). Which statement accurately describes how these four concepts fit together?

a. Suitability and FTC are identical terms that apply only at account opening, while the reason-why letter is an internal note that must never be shared with the client.
b. FTC is the umbrella principle for the whole relationship, suitability is the bridge from the KYC profile to a fitting recommendation, and the reason-why letter records that logic.
c. KYC replaces the need for a suitability assessment whenever a client signs a standard risk perception questionnaire.
d. Suitability is the broader umbrella principle that includes product manufacturing and claims handling, whereas FTC only checks whether the agent verified the client's Notice of Assessment (NOA).

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

Items marked ′ are variants on the same point: do one when you miss the main question.

169. A client participates in an employer's group retirement plan where her savings are held in a group segregated fund. She tells her advisor that her primary objective is to ensure her principal is guaranteed upon death for her heirs, and she assumes her current plan already does this because it has the words 'segregated fund' in its name. How should the advisor guide her based on the recommendation decision tree?

a. Confirm that all group segregated funds automatically carry at least a 75% death benefit guarantee just like individual contracts.
b. Explain that group segregated funds carry no death benefit guarantee by default, so her goal calls for an individual segregated fund or life insurance.
c. Recommend switching her retirement savings into a First Home Savings Account (FHSA) to lock in a 10–year maturity guarantee.
d. Advise her that she can simply name a contingent annuitant on her registered group retirement plan to guarantee the principal at death.

169′. An investor has non–registered savings that she plans to use within two years to purchase a home. An advisor considers recommending an individual segregated fund because of its maturity and death benefit guarantees. Why does this recommendation conflict with the recommendation decision tree?

a. Non–registered accounts are legally prohibited from holding individual segregated funds with a 75/75 guarantee.
b. Individual segregated funds do not offer any death benefit guarantee unless held inside a Registered Retirement Savings Plan (RRSP).
c. A two–year time horizon calls for an immediate payout annuity so that she can lock in a guaranteed stream of lifetime income.
d. Individual segregated funds mature in no less than 10 years, which clashes with a two–year need, so an FHSA and short–term options come first.

170. A husband holds funds in his individual Registered Retirement Savings Plan (RRSP) and wants to open a segregated fund contract. Because his wife is younger, he asks the advisor to name himself as the contract owner and his wife as the annuitant so the contract guarantees will last longer. If that is not possible, he proposes contributing to a spousal RRSP where he remains the contract owner and designates the beneficiary. How must the advisor respond?

a. Both proposals are valid because a spouse can always be named as the annuitant or controlled by the contributor in a registered contract.
b. The first proposal is invalid, but under a spousal RRSP the contributing spouse retains ownership and the sole right to designate beneficiaries.
c. Neither works: in his RRSP the owner must be the annuitant, and in a spousal RRSP the receiving spouse is sole owner and annuitant and names the beneficiary.
d. The first proposal is valid as long as the husband also names his wife as a contingent annuitant on the RRSP application form.

170′. An investor is opening a non-registered segregated fund contract using corporate funds and wants to know how ownership, the annuitant role, and collateral assignment differ from a personal RRSP contract. Which statement accurately describes the rules for a non-registered segregated fund contract?

a. Owner and annuitant may differ, even with a corporation as owner, and ownership can be transferred, the contract pledged as collateral, and a contingent annuitant named.
b. The contract owner and annuitant must still be the same individual, and the contract cannot be pledged as loan collateral.
c. A Social Insurance Number (SIN) is never required under any circumstances for a non-registered segregated fund contract, even when reportable investment income is generated.
d. Beneficiaries receive the death benefit immediately upon the death of the contract owner, even while the initial annuitant and contingent annuitant are still alive.

171. An 82-year-old client has suffered a stroke that limits her speech and writing ability. Her son holds a valid Power of Attorney (POA) for property and meets with the advisor to sign a new segregated fund application on his mother's behalf, while also asking to change her existing beneficiary designation from her late husband to her grandchildren. Under the general exam rule, what is the scope of the son's authority?

a. He may sign the application for her because of her incapacity, but that exception generally does not extend to naming or changing a beneficiary.
b. A Power of Attorney for property never allows signing a segregated fund application form under any circumstances.
c. Because he holds a Power of Attorney for property, he can freely sign the application form and name any new beneficiary he chooses without restriction.
d. The advisor should sign both the application form and the beneficiary change on the mother's behalf to avoid using the Power of Attorney.

171′. An investor is living abroad for an extended period and cannot sign a segregated fund application in person. She has granted her sister a valid Power of Attorney (POA) for property. The sister wants to sign the application form and also change the beneficiary on the investor's policy to the sister's own children. According to the exam, which action is permitted?

a. Neither signing the application nor changing the beneficiary is permitted when the investor is merely living abroad.
b. Both signing the application and changing the beneficiary to the sister's children are permitted under the general Power of Attorney rule.
c. The sister may sign the application under the POA exception, but the general rule gives her no power to name or change the beneficiary.
d. The advisor may verbally confirm the beneficiary change with the sister and omit any written documentation until the investor returns.

172. An advisor completes a thorough needs analysis and recommends an individual segregated fund that covers the client's retirement savings goal, while leaving the client's short-term emergency fund need unaddressed for now. Because the client understands English well and signs the application form immediately, the advisor wonders whether a reason-why letter is necessary and whether the unaddressed need should be mentioned. What is the rule?

a. A reason-why letter is optional when the client signs the application in person, and unaddressed needs should be left out to avoid confusing the client.
b. A reason-why letter is required only when the advisor recommends an equity fund based on its past three-year performance.
c. The advisor must either cover every single financial need in one transaction or decline the application, because leaving any need unaddressed is professional misconduct.
d. A reason-why letter is mandatory at the application stage, must be reviewed with and retained by both parties, and must explicitly state both the needs met and any needs left unaddressed.

172′. Which set of five elements must be documented in a compliant reason-why letter when an advisor submits a segregated fund application?

a. The advisor's commission rate, the fund's past three-year return ranking, the insurer's corporate history, the client's Social Insurance Number, and a waiver of the right of rescission.
b. Confirming known facts, verifying the client's instructions, naming needs met and unmet, explaining why the sale is suitable, and showing the client understands it.
c. Replacing the information folder and Fund Facts so the client only has to read one single summary letter at the time of application.
d. Recording only the final product name and guarantee percentage, without explaining the reasoning process behind the suitability judgment.

173. An advisor submits a segregated fund application after reviewing the Information Folder and the Fund Facts for each selected fund with the investor. After receiving the confirmation of purchase, the investor decides to cancel the purchase under the contractual right of rescission. Within what timeframe must the investor act, and how is the refund calculated?

a. Within 5 business days of signing the application, receiving the greater of the amount invested or the fund value on the date of application.
b. Within 2 business days of receiving the confirmation, getting back the lesser of the amount invested and the next-valuation-day value, plus fees paid.
c. Within 10 years of the contract effective date, receiving 100% of the initial deposit regardless of market declines.
d. At any time before December 31 of the purchase year, because the sample contract delivered with the application immediately completes the purchase.

173′. When an advisor delivers the mandatory disclosure documents for an Individual Variable Insurance Contract (IVIC), what is the specific role and requirement of the Fund Facts document compared to the Information Folder?

a. Fund Facts is prepared for each fund with data as of the prior December 31 in a standard format, and the advisor must review it with the investor.
b. Fund Facts is a single booklet covering all series of the insurer, and the advisor may substitute another series' booklet if the current one is out of stock.
c. Delivering a sample IVIC contract together with Fund Facts immediately makes the contract effective before the initial deposit is received.
d. Fund Facts creates a statutory 5-business-day rescission right under the provincial Insurance Act that refunds the higher of the deposit or market value.

174. An advisor is completing a segregated fund application with a client. To save time, the advisor decides to fill in the client's risk tolerance and investment objective sections using the advisor's own assumptions without asking the client, and compares a high-risk equity segregated fund against a money market fund without explaining the difference in asset categories. Which two fundamental rules has the advisor violated?

a. Application content must come from the investor, with the advisor only recording it, and comparing funds across categories needs an explanation.
b. The mandatory age-71 RRSP conversion rule and the age-85 Advanced Life Deferred Annuity (ALDA) deferral limit.
c. The rule requiring the advisor to personally guarantee the client's principal whenever a comparison across fund categories is made.
d. The rule that an advisor may never record answers on an electronic or paper application form, even when the investor dictates every answer.

174′. Throughout the segregated fund recommendation process—whether the advisor presents a single recommendation, a primary option with an alternative, or multiple options side by side—seven overarching regulatory principles apply from product design to after-sales service. Under what framework are these seven requirements grouped?

a. The formula that insurers use under Total Cost Reporting to calculate the dollar totals shown on each annual statement sent to their contract holders.
b. The exemption that lets a contributing spouse take back ownership of a spousal RRSP and transfer the contract to another family member.
c. The deemed receipt rule that starts the rescission clock on the earlier of actual receipt or the fifth business day after mailing.
d. Fair Treatment of Customers: client interests first, clear materials, ongoing information, avoiding conflicts, fewer unsuitable sales, relevant advice, fair complaints.

175. A candidate taking the LLQP exam encounters a question asking which sales charge options are described in the exam for segregated funds, and also wants to know how the exam wording compares to current rules in British Columbia. According to the exam, how are segregated fund sales charges described?

a. Only the advisor chargeback option is listed in the exam, because front-end load (FEL) and deferred sales charge (DSC) were never mentioned.

b. Deferred sales charges (DSC) were already banned on all existing and new contracts prior to 2022, requiring immediate unified clearance of all unmatured units.

c. Both front-end load (FEL) and deferred sales charge (DSC) are listed alongside each other, with a note that DSC is expected to be phased out.

d. Sales charges are prohibited on all Individual Variable Insurance Contracts unless approved by a court order under Section 20 of the Power of Attorney Act.

175′. An investor in British Columbia holds an existing segregated fund contract purchased before June 1, 2023 under a deferred sales charge (DSC) schedule, and now wants to open a brand-new segregated fund contract in 2026. How do the current rules in British Columbia apply to her existing DSC units and her new contract?

a. She can still select a DSC option on her new 2026 contract because the regulatory notice is not legally binding on licensees.

b. New contracts in BC may not include DSC since June 1, 2023 under the Financial Institutions Act, while old DSC schedules run out by each batch's purchase date.

c. All old DSC schedules were forcibly reset to zero on January 1, 2026 when Total Cost Reporting (TCR) took effect.

d. The ban on new DSC contracts is enforced under the provincial Insurance Act and requires converting all old DSC units into a payout annuity at age 71.

Chapter 26 · Segregated Fund (IVIC) and Annuity Contracts: Clause-by-Clause Guarantees and Administration Segregated Funds & Annuities

Items marked ′ are variants on the same point: do one when you miss the main question.

176. Victor holds two segregated fund contracts: Contract X is held inside a registered Retirement Savings Plan (RRSP), and Contract Y is a non-registered savings contract. Victor wants to name his adult son as a contingent annuitant on both contracts and pledge both contracts as collateral for a business line of credit. Which statement accurately describes what Victor is permitted to do?

a. He can name a contingent annuitant and pledge the contract as collateral on both Contract X and Contract Y because segregated funds are governed by provincial insurance law.

b. He may do both only on Contract Y, because a registered contract binds the owner and annuitant as one person and bars assignment or pledging.

c. He can name a contingent annuitant on both contracts to avoid probate, but neither Contract X nor Contract Y can ever be pledged as security for a loan.

d. He can pledge Contract X as collateral if he signs a written amendment, but he can only name a contingent annuitant on Contract Y.

176′. Helena owns a locked-in retirement account (LIRA) invested in a segregated fund contract, while her sister owns a non-registered segregated fund contract. Both sisters ask their advisor whether they can change the annuitant on their existing contracts to their respective children while keeping ownership themselves. What should the advisor explain?

a. Both sisters can designate their children as contingent annuitants because all individual variable insurance contracts allow separation of the owner and annuitant roles.

b. Neither sister can separate the owner and annuitant roles, because an insurer fixes all three parties permanently once any segregated fund contract is issued.

c. Helena can add a contingent annuitant to her LIRA contract if her spouse signs a waiver, whereas her sister cannot modify a non-registered contract.

d. Helena's LIRA requires her to remain the annuitant with no contingent annuitant, while her sister's non-registered contract can separate owner and annuitant and name one.

177. While reviewing a segregated fund contract with a new client, an advisor explains which provisions are legally or contractually fixed guarantees and which are administrative rules set at the insurer's discretion. In addition, the client asks whether the advisor can verbally waive the short-term trading fee for the first year. Which statement is correct?

a. The number of free switches per year is fixed by provincial insurance legislation, and the advisor's verbal waiver of the short-term trading fee is legally binding on the insurer.

b. The requirement to obtain the irrevocable beneficiary's consent before changing the designation is set at each insurer's discretion, while the maximum age limit for resets is fixed by statute.

c. Irrevocable beneficiary consent is legally required, free switches per year are set by each insurer, and any waiver needs a written amendment from the insurer signed by the owner.

d. Both the maturity guarantee percentage after issue and the specific format of Power of Attorney forms are purely administrative rules that the insurer can unilaterally alter without notice.

177′. An advisor tells a client that five core contract actions—purchase, switch, reset, withdrawal, and termination—require investor confirmation, and promises verbally that the insurer will allow resets up to age 90 even though the contract states age 80. How are these two points treated under contract rules?

a. Investor confirmation of the five actions is mandatory, but the verbal promise on the reset age has no effect unless the insurer issues a written amendment signed by the owner.

b. Investor confirmation is only required for initial purchases and terminations, while the advisor's verbal promise binds the insurer under general agency law principles.

c. Both investor confirmation for switches and the 80-year reset age limit are statutory provisions under the Financial Institutions Act that cannot be modified even by written amendment.

d. The reset age limit is fixed uniformly across Canada by the Insurance Act, so only a provincial court order could ever extend it to age 90 for this client.

178. An exam question framed in the style of the 2022 exam manual asks about the status of deferred sales charges (DSCs) on new segregated fund contracts, while a compliance officer in British Columbia also reviews which statute enforces the ban on issuing new DSC contracts versus which statute governs beneficiary designations inside the contract. Which statement correctly addresses both the exam-manual position and the BC statutory division?

a. The manual says DSCs are expected to be phased out, while new DSC contracts have been banned since June 1, 2023; in BC the ban rests on the Financial Institutions Act and beneficiary rules on the Insurance Act.

b. Both the 2022 exam manual and current BC law permit insurers to issue new DSC segregated fund contracts indefinitely, and both market conduct and beneficiary designations are governed exclusively by the Insurance Act.

c. The exam manual states that DSCs were banned in 2015, and in BC all beneficiary designations and creditor protection rules are governed by the Financial Institutions Act rather than the Insurance Act.

d. Current rules require every pre-2023 DSC contract to be terminated immediately under the Insurance Act, while new sales charge arrangements are regulated only under federal banking law.

178′. A candidate preparing for the licensing exam compares an exam-style practice question asking about current regulatory trends for deferred sales charges (DSCs) on segregated funds with a client's question at the counter today about buying a new DSC contract in British Columbia. Which pairing of answers is accurate?

a. For the exam-style question, answer that DSCs are permanently guaranteed by statute; at the counter today, tell the client that new DSC contracts are still available on 10-year terms.

b. For the exam-style question, answer that DSCs only apply to payout annuities; at the counter today, tell the client that all existing pre-2023 DSC schedules have been voided.

c. Exam-style: regulators are moving to phase out DSCs; at the counter: no, because BC has prohibited new DSC segregated fund contracts since June 1, 2023.

d. For both questions, answer that DSCs were replaced by a mandatory front-end load fee on all segregated fund contracts under the Insurance Act.

179. Four years ago, Gavin deposited $80,000 of non-registered cash into a 10-year segregated fund contract with a 75% maturity guarantee. No distributions or withdrawals have occurred, so his adjusted cost base (ACB) remains $80,000. Today, when the market value is $86,000, Gavin requests his first switch of the year from a growth fund to a balanced fund. Under his contract, this first annual switch is free of insurer switch fees, and the switch simultaneously triggers a maturity guarantee reset that re-dates the maturity under the contract terms. Assuming a 50% capital gains inclusion rate, what are the consequences of this transaction?

a. There is no taxable gain because the switch is within the insurer's free annual switch allowance, and the contract still matures six years from today.
b. Gavin realizes a taxable capital gain of $6,000 for the current tax year, and the maturity date remains unchanged at six years from today.
c. There is no taxable disposition until Gavin withdraws cash from the contract, but the maturity date is extended to 10 years from the date of the switch.
d. A $6,000 capital gain, so a $3,000 taxable capital gain, despite the fee waiver; the reset also moves the maturity date to 10 years from today.

179′. Six years ago, Miranda invested $40,000 into a non-registered 10-year segregated fund contract with no subsequent ACB adjustments. Today, with the market value at $45,000, she uses her free annual switch privilege to move into a bond fund, which also triggers a maturity reset under her contract terms. Using a 50% capital gains inclusion rate, what must her advisor disclose before confirming the instruction?

a. Because the switch is free of administrative charges and stays inside the same umbrella contract, Miranda will face neither tax consequences nor any change to her remaining four-year maturity timeline.
b. Although there is no switch fee, the switch triggers a taxable disposition generating a $2,500 taxable capital gain ($5,000 capital gain at 50%), and the reset restarts the 10-year maturity clock from today.
c. Miranda will owe a 2% short-term trading fee on the $45,000 switch value because she is changing funds prior to the 10-year maturity date.
d. The reset will lock in the $45,000 value without extending the maturity date, and the $5,000 gain will be deferred until the contract matures in four years.

180. Walter is both the policy owner and the annuitant of a segregated fund contract that matures in ten days. Three years ago, Walter made a partial withdrawal from the contract. Last year, Walter lost mental capacity due to illness; prior to becoming incapacitated, he had executed a valid Power of Attorney for property (POA) naming his son, Derek, as his attorney. Walter's daughter, Fiona, is the named beneficiary on the contract. At maturity in ten days, the contract's market value is lower than its guarantee. Who has the authority to claim the maturity payout, what documentation is required, and how is the payout calculated?

a. Fiona claims the payout as the named beneficiary by submitting an Attending Physician's Statement (APS) confirming Walter's incapacity, and she receives the original unadjusted maturity guarantee.
b. Derek, acting under the POA for property, claims on Walter's behalf with no death certificate, and the payout is the guarantee reduced for the earlier partial withdrawal.
c. Derek and Fiona must jointly submit a claim along with a medical certificate of incapacity, and the insurer pays only the current market value because a prior withdrawal voids the maturity guarantee.
d. Walter's estate executor must claim the maturity benefit because Walter is incapacitated, and the insurer pays the original maturity guarantee in full.

180′. Beatrice was the owner and annuitant of a segregated fund contract on which her nephew, Lucas, held a Power of Attorney for property (POA) during her lifetime, and her niece, Chloe, was named as the revocable beneficiary. Beatrice passed away yesterday at a time when the contract's market value was below its death benefit guarantee (which had been adjusted downward for a withdrawal she made two years ago). Who is entitled to file the claim now, what proof is required, and what amount is payable?

a. Chloe files a death claim with satisfactory proof of death and entitlement, and receives the death benefit guarantee as reduced for the prior withdrawal.
b. Lucas files the claim using his Power of Attorney for property without needing a death certificate, and receives the current market value of the fund.
c. Chloe files the death claim without needing any medical or death documentation at all, and receives the original unadjusted death benefit guarantee.
d. Beatrice's estate administrator overrides Chloe's beneficiary designation because a partial withdrawal was made on the contract within the last three years.

181. Harold and his spouse, Irene, purchased a joint and last survivor annuity with a 15-year guarantee period. Harold is the primary annuitant, Irene is the co-annuitant, and their adult son, Kevin, is the named beneficiary. Six years after annuity payments began, Harold dies while Irene is still alive. Who is entitled to receive payments under the annuity contract right now?

a. Irene becomes the sole annuitant and continues to receive the annuity payments; Kevin has no right to claim any guarantee period balance while Irene is still alive.

b. Kevin immediately receives the remaining nine years of guaranteed payments because the primary annuitant died before the 15-year guarantee period expired.

c. The remaining nine years of guaranteed payments are split equally between Irene and Kevin until the 15-year guarantee period ends.

d. The contract terminates upon the primary annuitant's death with no further payments to either Irene or Kevin.

181′. Compare two annuity contracts after death occurs: Contract 1 is a single life annuity with no guarantee period and no death refund option, where the annuitant dies two years after payments start. Contract 2 is a joint and last survivor annuity with a 10-year guarantee period, where both the annuitant and the co-annuitant die in Year 7. In which contract does the named beneficiary receive a death benefit?

a. Both contracts, because provincial insurance law guarantees a minimum 75% return of principal on every annuity contract after the annuitant dies.

b. Contract 1 only, because a single life annuity always refunds any unused principal to the estate or beneficiary when the annuitant dies early.

c. Neither contract, because once a payout annuity begins, beneficiaries lose all claim rights after the fifth year of payments.

d. Contract 2 only, since both annuitants died within the 10-year guarantee period, while Contract 1 has no guarantee period or refund option.

182. Graham holds an enduring Power of Attorney for property (POA) for his elderly aunt in British Columbia. He meets with an insurance advisor to sign a new segregated fund application on his aunt's behalf and also asks to change the existing beneficiary designation on another segregated fund contract his aunt already owns from her cousin to Graham's daughter. Under the exam guidance and British Columbia's Power of Attorney Act (s. 20), which statement is correct?

a. Because a valid POA for property grants full authority over financial assets, Graham can both sign the application and freely change the beneficiary to his daughter without restriction.
b. An attorney under a POA for property is strictly prohibited from signing any segregated fund application form, so only the aunt can sign in person.
c. Graham may sign the application, but naming a beneficiary needs separate legal advice, and under s. 20 changing the existing designation requires court authorization.
d. Graham can change the existing beneficiary on his aunt's contract without court approval as long as he submits a reason–why letter co–signed by the insurance advisor.

182′. In British Columbia, an attorney acting under an enduring Power of Attorney (POA) is moving an incapacitated client's maturing segregated fund into a replacement contract of a similar instrument and is also establishing a brand–new contract with separate cash funds. Under BC's Power of Attorney Act (s. 20), what are the rules regarding beneficiary designations on these instruments without obtaining a court order?

a. The attorney can name any family member as beneficiary on both the replacement contract and the brand–new contract because BC exempts POA attorneys from all beneficiary restrictions.
b. On the replacement, he may keep the beneficiary the adult named while capable; on the brand–new contract, a new designation is limited to the adult's estate.
c. The attorney must name himself as irrevocable beneficiary on both contracts so that he can hold any death proceeds in trust for the family.
d. Both the replacement contract and the new contract must forfeit all death benefit guarantees because a POA attorney cannot sign insurance applications.

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

Items marked ′ are variants on the same point: do one when you miss the main question.

183. A manufacturing company sponsors a Defined Contribution Pension Plan (DCPP) and serves as the legal plan administrator. To streamline operations, the company hires an insurer to manage the daily investment funds and record-keeping. If an investment option performs poorly due to a lack of oversight, how does the fiduciary duty under provincial pension legislation apply?

a. The legal administrator keeps fiduciary oversight duties under the prudent person rule even though daily operations are outsourced.
b. Fiduciary duty transfers entirely to the insurer once the administrative services contract for the plan has been signed.
c. A DCPP carries no fiduciary duty for the administrator at all because employees make their own investment choices.
d. The managing general agent (MGA) assumes statutory fiduciary responsibility for all group pension plans.

183′. A logistics firm acts as both plan sponsor and legal administrator for its employees' registered pension plan. The board of directors delegates asset custody and fund reporting to an insurance company. Which statement accurately describes the administrator's ongoing legal obligation?

a. The board is relieved of the prudent person rule as long as the insurer submits complete annual financial reports to it.
b. Only defined benefit plans impose fiduciary duties on the administrator; defined contribution plans impose none at all.
c. The administrator stays bound by the prudent person rule to act for plan members and cannot outsource its supervisory duty.
d. Individual plan members assume the fiduciary duty for monitoring the insurer once they enrol in the plan.

184. An engineering firm with fluctuating annual profits wants to set up a group plan funded out of company profits. However, the founder insists that employees must also be allowed to contribute their own money into this same plan through payroll deductions, and wants the founder's brother—who owns 10% of the company's shares—to participate. Why cannot a Deferred Profit Sharing Plan (DPSP) meet these requirements?

a. Because DPSP funds are strictly locked in under provincial pension standards legislation until the member reaches age 71.
b. Because only the employer may contribute to a DPSP, and employees owning 10% or more of the shares or related to the employer cannot join.
c. Because a DPSP cannot legally coexist with a Defined Contribution Pension Plan (DCPP) inside the same company.
d. Because employer contributions to a DPSP are taxed immediately as current employment income in the year they are contributed.

184′. A three-year-old software startup with an average employee age of 28 already offers a Defined Contribution Pension Plan (DCPP) with fixed contributions, and now wants to add a flexible layer that shares profits in good years without locking the firm into fixed obligations in lean years. Which arrangement best achieves this goal?

a. Keep the DCPP as the base and add an employer-funded Deferred Profit Sharing Plan (DPSP) paid from profits for eligible employees.
b. Replace the DCPP with a contributory DPSP in which both the startup and its engineers each contribute 5% of salary.
c. Establish a Defined Benefit Pension Plan (DBPP) so the startup has no funding obligation when investment returns drop.
d. Set up a DPSP specifically for the majority shareholders who each own 10% or more of the company.

185. Clara earns $80,000 in pensionable income this year and participates in her employer's Defined Contribution Pension Plan (DCPP), where she contributes 5% of her salary and her employer matches 5%. Assuming an 18% RRSP calculation rate, no unused carry-forward room, and no PAR or PSPA, how much new personal RRSP contribution room will Clara have next year, and what is her Pension Adjustment (PA)?

a. A DCPP does not generate a PA, leaving her full $14,400 RRSP contribution room untouched for next year.
b. Her PA only counts the employer's 5% contribution and ignores her own 5% contribution.
c. Her PA is $8,000, which reduces her $14,400 base entitlement to $6,400 of new personal RRSP room for next year.
d. Her PA is $14,400, which eliminates all of her new personal RRSP room for next year.

185′. Marcus works at a retail headquarters earning $60,000 per year (the same as his prior year's earned income). He participates in the company's Group RRSP (GRRSP), where both he and his employer contribute 5% of his salary this year. Assuming an 18% RRSP rate and no carry-forward room, how much can Marcus still contribute to his personal RRSP this year, and does the GRRSP generate a Pension Adjustment (PA)?

a. He can contribute $10,800 to his personal RRSP because GRRSP contributions are completely separate from personal RRSP room.
b. He can still contribute $4,800 to his personal RRSP this year ($10,800 limit minus $6,000 GRRSP contributions), and the GRRSP does not generate a PA.
c. Only his own 5% contribution uses current RRSP room, while the employer's 5% contribution creates a PA for next year.
d. He can contribute $4,800 to his personal RRSP, and the GRRSP also generates a $6,000 PA that reduces next year's room a second time.

186. A company offers employee matching contributions through one of four vehicles: a defined contribution pension plan (DCPP), a group RRSP (GRRSP), a deferred profit sharing plan (DPSP), or a pooled registered pension plan (PRPP). In which of these plans is the employer's contribution treated as a taxable benefit (additional employment income) to the employee in the year the contribution is made?

a. The Defined Contribution Pension Plan (DCPP) only, because it is a registered pension.
b. The Deferred Profit Sharing Plan (DPSP) and the Pooled Registered Pension Plan (PRPP).
c. None of them, because all employer retirement contributions are tax-deferred until withdrawal.
d. The Group RRSP (GRRSP) only, as its employer contributions count as additional salary.

186′. An employer makes contributions for each employee into both a Group TFSA and a Defined Contribution Pension Plan (DCPP). How are these two employer contributions treated on the employee's income tax return for the current year?

a. The Group TFSA contribution is a current taxable benefit, whereas the DCPP contribution is not included in current taxable income.
b. Both the Group TFSA and the DCPP employer contributions are excluded from the employee's current taxable income.
c. The DCPP contribution is taxed as current salary, while the Group TFSA contribution is fully deductible from income.
d. Both contributions are taxed immediately as salary and also generate a Pension Adjustment (PA) for next year.

187. An insurance agent is helping a corporate employer set up a new group retirement plan. How do the agent's disclosure obligations and the application workflow in a group retirement plan differ from selling an individual retail policy?

a. Each employee first applies individually to the insurer through a managing general agent (MGA), and the employer signs the master application last.
b. Disclosure of insurer, compensation and conflicts goes to the sponsor, and the sponsor applies first, with members enrolling individually after underwriting.
c. Once the group contract is issued, the agent's duty ends, so workforce changes such as mass layoffs require no follow-up from the agent.
d. The agent is prohibited from disclosing compensation or conflicts to the corporate sponsor in order to protect insurer confidentiality.

187′. After a corporate sponsor's group pension plan has been operating for two years, the company undergoes a major restructuring with significant layoffs. What is the group agent's professional responsibility during this period?

a. Wait until the plan's three-year provincial assessment deadline arrives before contacting the plan sponsor about the layoffs.
b. Instruct the managing general agent (MGA) to freeze all vested employee accounts immediately until the restructuring ends.
c. Review the plan promptly and help the sponsor adjust its design to reflect the major workforce changes or a possible termination.
d. Have every remaining employee submit a brand-new master group application so that the insurer can re-underwrite the company.

188. Helena is retiring and wants to start drawing annual retirement income from two group accounts: a locked-in Defined Contribution Pension Plan (DCPP) and an unlocked Deferred Profit Sharing Plan (DPSP). If she transfers the DCPP into a Life Income Fund (LIF) and the DPSP into a Registered Retirement Income Fund (RRIF), how do the annual withdrawal rules compare?

a. A LIF has both a statutory minimum and a maximum annual withdrawal, whereas a RRIF has a minimum but no maximum.
b. Both a LIF and a RRIF impose identical statutory maximum withdrawal limits to preserve retirement capital.
c. A LIF does not allow any income withdrawals and only holds locked-in investments until death.
d. Because her DCPP is vested under BC PBSA, she can transfer the DCPP directly into an unlocked RRIF with no maximum limit.

188′. Victor resigns from his employer long before retirement and wants to move his locked-in Defined Contribution Pension Plan (DCPP) balance away from the former employer's investment menu so he can manage the investments himself without drawing any retirement income yet. Which account should receive the transfer?

a. An unlocked personal RRSP, because leaving the employer automatically removes the locking-in rules on the balance.
b. A Registered Retirement Income Fund (RRIF), which allows him to defer all withdrawals indefinitely.
c. A Group TFSA at his new employer, so that future investment growth on the balance will no longer be taxed.
d. A Locked-in Retirement Account (LIRA), which keeps the money locked in but lets him invest it himself.

189. An employer sponsors a retirement plan and asks the agent two technical questions: first, what criterion determines whether a group plan is classified as a Capital Accumulation Plan (CAP); and second, if the plan offers group segregated funds as investment options, whether they include the same death benefit guarantees as retail segregated funds.

a. A Defined Benefit Pension Plan (DBPP) is always a CAP, and group segregated funds carry a mandatory death benefit guarantee for members.
b. Any plan where the employer contributes is a CAP, and group segregated funds always provide a retail death benefit guarantee.
c. A non-DBPP plan is a CAP if members choose among two or more options, and group segregated funds usually lack death benefit guarantees.
d. Only a Group TFSA qualifies as a CAP, and group segregated funds require medical underwriting for death benefit guarantees.

189′. A corporate sponsor wants to give employees control over how their retirement savings are invested and is comparing a Defined Benefit Pension Plan (DBPP) with a Group RRSP (GRRSP) offering two or more group segregated funds. Which statement accurately guides the sponsor?

a. The DBPP is classified as a Capital Accumulation Plan (CAP) because its benefit formula guarantees a retirement benefit to members.
b. The GRRSP with two or more investment options is a CAP, though its group segregated funds generally carry no death benefit guarantee.
c. Choosing group segregated funds inside the GRRSP ensures that every member receives a retail-style death benefit guarantee on deposits.
d. Neither plan can be a CAP because Capital Accumulation Plans only exist for individual retail investors.

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

Ethics & Professional Practice

Items marked ′ are variants on the same point: do one when you miss the main question.

190. Marcus, a licensed life insurance agent in British Columbia, hires an unlicensed administrative assistant to help grow his practice. Marcus instructs the assistant to call prospective clients from a purchased lead list to schedule insurance review appointments, prepare life insurance policy illustrations before meetings, and forward signed applications to the managing general agent (MGA). Which assessment of these duties is correct?

a. All three tasks are permissible because the assistant is neither giving financial advice nor signing the insurance application.

b. Booking insurance meetings by phone, preparing illustrations and forwarding applications all require a licence, and the calls must also respect DNCL rules.

c. The assistant may call prospects to book appointments and forward signed applications, provided only Marcus himself prepares the illustrations.

d. The assistant can avoid licensing rules by sending bulk marketing emails to the prospects instead of calling them on the telephone.

190′. An incorporated insurance agency in British Columbia employs an unlicensed receptionist. When walk-in clients visit the office, the receptionist collects their initial premium cheques, helps them fill out and submit policy applications, and generates basic life insurance illustrations while the licensed agent is away. Why does this arrangement violate regulatory rules?

a. Because an incorporated agency in British Columbia is prohibited from employing any staff who do not hold a corporate MGA licence.

b. Because only an exclusive captive agent of an insurer is permitted to collect premiums or generate policy illustrations.

c. Because receiving applications, collecting premiums and preparing illustrations are activities that require the employee to be licensed.

d. Because the BC Insurance Act requires at least two corporate signing officers to witness every premium cheque collected at an agency.

191. A life insurance agent in British Columbia meets two prospective applicants on the same day: Arthur, a mentally sharp 100-year-old who wants to sign an annuity contract on his own, and Chloe, a 17-year-old student who understands policy terms and wants to apply for life insurance on her own life. How does the law of legal capacity apply to Arthur and Chloe?

a. Both may sign alone, because capacity has no maximum age and anyone 16 or older can contract for insurance on their own life.
b. Arthur must have an adult family member co-sign due to his advanced age, whereas Chloe can sign alone because the age of majority in British Columbia is 16.
c. Arthur can sign alone, but Chloe's parents must apply on her behalf because no one under the BC age of majority of 19 can enter into a life insurance contract.
d. Neither Arthur nor Chloe can sign alone without a representation agreement approved by the Public Guardian and Trustee.

191′. In British Columbia, a mother wants to take out a life insurance policy on her 15-year-old son, while her 16-year-old daughter wants to purchase a life insurance policy on her own life and also be named as the sole beneficiary to directly collect proceeds on her grandmother's policy today. Which statement accurately reflects BC age rules?

a. The 15-year-old son can sign his own policy application, because capacity in British Columbia depends solely on maturity rather than any minimum age.
b. Neither child can be insured or purchase insurance until reaching the British Columbia age of majority of 18.
c. The 16-year-old daughter can directly receive and give a valid discharge for the grandmother's death benefit, because contracting capacity at age 16 includes full beneficiary rights.
d. The mother may insure her 15-year-old son on insurable interest, and the daughter may buy her own policy but cannot directly collect proceeds as a beneficiary.

192. Elena, a business owner in British Columbia, applies to be the policyowner and payer of a new life insurance policy on the life of her adult friend, Victor, with whom she has no family or financial relationship. Under BC Insurance Act s.45, under what condition is this contract valid at the time it takes effect?

a. The contract is void under all circumstances because an applicant must always have both a financial insurable interest and the insured's written consent.
b. The contract is valid only if Elena proves that Victor is under age 19 and obtains approval from the Insurance Council of British Columbia.
c. Although s.45(1) voids a policy lacking insurable interest, it is valid under the s.45(2) exception if Victor consents in writing to the coverage.
d. The contract becomes valid only after it has remained in force for the 2-year incontestability period under s.52.

192′. An aunt in British Columbia wants to purchase and own a life insurance policy on the life of her 15–year–old niece, even though the aunt has no statutory insurable interest in the child. Under BC Insurance Act s.45, how can this policy be validly put in force?

a. By obtaining the written consent of the child's parent or a person standing in the place of a parent, since the insured child is under 16 years of age.
b. By having the 15–year–old niece sign a written consent form herself in the presence of two corporate officers.
c. It cannot be put in force under any exception because insuring a minor without insurable interest violates public policy on the same level as arson for hire.
d. By registering an ordinary Power of Attorney signed by the niece with BCFSA before paying the first premium.

193. Grace calls her mother's life insurance agent in Richmond, British Columbia. Grace explains that her mother now has severe cognitive impairment and cannot make decisions. Grace brings an uncertified photocopy of a Power of Attorney signed three years ago and demands that the agent immediately change the beneficiary on her mother's $400,000 permanent life insurance policy from a distant relative to Grace. How must the agent handle this request?

a. Accept the photocopy temporarily so the change takes effect immediately, because British Columbia allows any attorney under an ordinary Power of Attorney to change beneficiaries freely.
b. Verify that the document is a Representation Agreement under c. 405, which automatically authorizes changing life insurance beneficiaries without insurer review.
c. Have Grace sign a new will on her mother's behalf containing a beneficiary declaration under s.61 of the BC Insurance Act.
d. Confirm it is an Enduring Power of Attorney, get a notarized certified true copy, send it to the insurer for review, and check whether court authorization is needed.

193′. An aging business owner in British Columbia grants his nephew an ordinary Power of Attorney (PoA) to manage his financial affairs. Two years later, the business owner suffers a stroke that leaves him mentally incapable. The nephew asks the life insurance agent why the insurer restricts an attorney from freely changing beneficiary designations when transferring funds between financial institutions. Which statement correctly explains both the status of the ordinary PoA and the exam rationale for the beneficiary restriction?

a. The ordinary PoA remains valid after incapacity, and the restriction exists solely to protect the insurer's underwriting profit.
b. The ordinary PoA ended at incapacity, and the restriction stops an attorney from indirectly revoking the original designation by moving funds elsewhere.
c. The ordinary PoA converts automatically into a will upon incapacity, allowing the nephew to change the beneficiary through probate.
d. The ordinary PoA is valid if the agent agrees to act as co-attorney and relies on the agent's Errors and Omissions (E&O) insurance to cover property management.

194. When David and his former spouse separated in Vancouver, they signed a separation agreement requiring David to maintain his former spouse as the beneficiary of his $500,000 term life insurance policy until their children reached adulthood. However, the former spouse was never designated as an irrevocable beneficiary with the insurer. Two years later, David remarried, logged into the insurer's online portal to change the beneficiary to his new spouse, and died two years after that without the insurer ever receiving a copy of the separation agreement or any court order. Under the BC Insurance Act, what is the legal outcome?

a. The insurer may pay the new spouse on the latest designation and is discharged under s.77, leaving the former spouse to sue David's estate.
b. The online change is automatically void because signing a separation agreement under the Family Law Act converts a revocable beneficiary into an irrevocable beneficiary under s.60.
c. The death benefit is divided equally between the former spouse and the new spouse under the five-day survival rule of the Wills, Estates and Succession Act.
d. The policy is seized by David's creditors because changing a beneficiary after remarriage removes creditor protection under s.65.

194′. Following a divorce in British Columbia, a court issues a support order under Family Law Act s.170(e) requiring Sophia to maintain her former spouse as the beneficiary of her $500,000 life insurance policy. What step is required to ensure Sophia cannot unilaterally change the beneficiary designation on the policy without the former spouse's consent, and what can the insurer do under s.82 if competing claimants later demand the proceeds?

a. Sophia only needs to mention the policy in an unsigned note, and the insurer must forfeit the disputed proceeds to BCFSA.
b. The former spouse must register the policy under the Canada Health Act, and the insurer must cancel the whole contract if any dispute later arises.
c. Deliver an irrevocable designation to the insurer's head or principal office in Canada while Sophia is alive; if claims compete, the insurer may pay into court (s.82).
d. The agent must hold the policy document in a locked cabinet, which legally prevents the policyholder from contacting the insurer about it for 6 years.

195. A client in British Columbia purchases a permanent life insurance policy and pays the agent $18,000 in cash split into two $9,000 payments within the same 24-hour window. The agent wonders whether the transaction must be reported to FINTRAC under the PCMLTFA, and also asks which privacy statute governs his collection of client records for purely intra-provincial business in BC. Which statement is correct?

a. No FINTRAC report is required because neither cash payment reached $10,000 on its own, and federal PIPEDA exclusively governs all intra-provincial insurance records in BC.
b. A large cash transaction report is required because the two payments total $18,000 within 24 hours, and BC's PIPA governs intra-provincial business.
c. Only the managing general agent (MGA) has a legal duty to report suspicious or large cash transactions, so the individual agent cannot be penalized personally.
d. Because insurance contracts are under provincial jurisdiction in the Constitution Act, 1867, neither federal PCMLTFA nor privacy legislation applies to BC life agents.

195′. A life insurance agent in British Columbia suspects that a client is using a non-exempt life insurance product to launder illicit funds, and also transfers personal client data across provincial borders to an affiliate in another province. Who bears the statutory responsibility for reporting the suspicious transaction to FINTRAC, and which privacy law applies to the cross-border data flow?

a. Only the insurer's chief compliance officer is liable for FINTRAC reporting, and BC's Representation Agreement Act governs cross-border data.

b. The agent is exempt from reporting unless the cash amount exceeds $74,600, and the BC Insurance Act s.42 governs cross-provincial privacy.

c. The client must self-report to BCFSA within 10 business days, and provincial PIPA exclusively governs cross-border data transfers.

d. The agent personally bears the reporting duty and faces penalties including imprisonment, and federal PIPEDA applies to data crossing provincial borders.

196. A life insurance agent in British Columbia is conducting a disability and retirement needs analysis for Sophia, an unincorporated self-employed graphic designer who has never opted into any special federal program, and for her 65-year-old retired father, who collects both the Guaranteed Income Supplement (GIS) and Old Age Security (OAS). Which statement accurately describes how government benefit programs apply to Sophia and her father?

a. Sophia qualifies for up to 26 weeks of regular Employment Insurance (EI) sickness benefits at 55% of earnings, and both OAS and GIS are tax-free benefits funded by employer payroll contributions.

b. Sophia is covered by compulsory provincial workers' compensation for 90% of her net income without paying premiums, and her father's CPP pension is non-contributory and tax-free.

c. Sophia does not qualify for regular EI, making private disability cover key; her father's OAS is non-contributory and taxable, and his GIS is tax-free.

d. Sophia must still pay quarterly BC Medical Services Plan (MSP) premiums of $1,800 per year, which covers her prescription drugs, dental care, and routine eye exams.

196′. In British Columbia, a salaried employee earning $90,000 per year asks his insurance agent how the Canada Pension Plan (CPP), provincial workers' compensation, and private group health plans coordinate when he faces an injury or medical expense. Which explanation is accurate?

a. Workers' compensation is an employer-funded, no-fault plan in which workers give up the right to sue, and coordination stops two group plans paying the same expense twice.

b. CPP is funded entirely by federal general tax revenues, and an employee injured at work can both collect workers' compensation and sue the employer in civil court for negligence.

c. In British Columbia's government-operated auto insurance system, 'no-fault' means the insurer never determines who caused the accident, and both spouses' group health plans pay 100% each on the same dental bill.

d. CPP disability benefits pay 55% of weekly earnings for up to 26 weeks for any minor short-term illness, replacing Employment Insurance.

Chapter 29 · Insurance Policy Provisions Ethics & Professional Practice

Items marked ′ are variants on the same point: do one when you miss the main question.

197. Noah applied for a $500,000 term life insurance policy without paying the initial premium at the time of application. Due to a hobby risk, the insurer issued the policy with an exclusion rider and an increased premium. The agent received the policy from the insurer on Monday and handed it to Noah on Wednesday, when Noah paid the first premium and confirmed his health had not changed, but Noah did not sign the acceptance form for the modified terms until Friday. When did the contract take effect?

a. On Monday, when the insurer unconditionally delivered the issued policy to its authorized agent.

b. On Friday, when Noah signed the acceptance of the insurer's counter-offer after paying the initial premium with no change in insurability.

c. On Wednesday, when the policy was physically handed to Noah and the initial premium was paid while his health remained unchanged.

d. On the original application date, because paying the first premium retroactively backdates coverage to the time of the offer.

197′. Grace applied for a $750,000 life insurance policy and did not pay the first premium with the application. The insurer approved the application as applied for and sent the policy to the agent. Between the application date and the delivery appointment, Grace was advised by her doctor to undergo a biopsy for a newly discovered nodule. At delivery, she offered to pay the first premium. How does this health change affect the taking effect of the policy?

a. The policy takes effect immediately upon payment because the insurer already completed underwriting and issued the contract.

b. The policy takes effect, but the insurer will automatically add a 2-year exclusion for any condition related to the biopsy.

c. The agent must still deliver the policy because checking health at delivery is only a courtesy and not a legal requirement.

d. The policy cannot take effect as issued because a change in insurability occurred before delivery and initial premium payment.

198. Lucas purchased a $500,000 term life insurance policy. On the application, he accidentally stated his birth year as 3 years younger than his actual age (which was still within the policy's insurable age limit), and he also checked 'non-smoker' even though he smoked cigars every week. Lucas died of heart disease within the first 2 years of the policy. How will the insurer handle these two inaccuracies discovered during the claim investigation?

a. Both inaccuracies are adjusted proportionally by reducing the $500,000 death benefit to match what the premiums paid would have bought for a smoking insured 3 years older.
b. The age error makes the contract void immediately, whereas the cigar smoking is ignored because smoking only 2 or 3 cigars a week is an innocent oversight.
c. An age misstatement alone would adjust the face amount to what the premium buys at the true age, but the smoking misrepresentation within 2 years allows the insurer to void the policy.
d. The insurer must pay the full $500,000 because Lucas died of heart disease rather than lung cancer, so the smoking statement is immaterial.

198′. Three years after purchasing a $500,000 permanent life insurance policy, Victor died. During the claim review, the insurer discovered that Victor had genuinely miscalculated his birth year on the application, making himself appear 3 years younger than his true age (which remained below the policy's maximum issue age). No other inaccuracies existed. What action will the insurer take?

a. Pay a reduced death benefit equal to the coverage amount that the premiums paid would have purchased at Victor's true age.
b. Pay the full $500,000 face amount because the 2-year incontestability period has expired and the age error was made in good faith.
c. Void the policy and refund all premiums paid, because age is a material fact for life insurance underwriting.
d. Pay the full $500,000 face amount after deducting 3 years of unpaid age-adjusted premium differences plus interest.

199. Three years after her $750,000 life insurance policy took effect, Chloe passed away. While reviewing the claim, the insurer found medical records proving that Chloe had been diagnosed with a serious heart condition just before applying and had deliberately omitted this diagnosis and her specialist visits on the application to secure standard rates. How does the incontestability provision apply here?

a. The insurer can still contest and void the policy because fraudulent misrepresentation is excluded from the 2-year incontestability protection.
b. The insurer must pay the $750,000 claim in full because the policy has been in force for more than 2 years during the insured's lifetime.
c. The insurer must pay a reduced benefit based on the substandard premium rate Chloe would have been charged had she disclosed the condition.
d. The insurer can contest the policy only if Chloe died within 60 days of the 2-year anniversary of the policy issue date.

199′. Three years after his $500,000 life insurance policy took effect, Owen died. During the claim review, the insurer discovered that Owen had failed to mention a minor clinic visit from several years before the application because he had genuinely forgotten about it. There was no intent to deceive. What is the legal outcome of the claim?

a. The insurer can void the policy because any omission of medical history allows rescission regardless of how long the policy has been in force.
b. The insurer can deduct the value of the omitted medical risk from the $500,000 payout under the misstatement rule.
c. The insurer cannot void the policy for this omission because the 2-year incontestability period has passed and there was no fraud.
d. The beneficiary must prove in court that the clinic visit had no connection to Owen's cause of death before the insurer pays.

200. In 2015, Daniel purchased a $750,000 permanent life insurance policy and properly designated his wife, Sofia, as the irrevocable beneficiary by filing the declaration with the insurer's head office. In 2024, they divorced, and their divorce agreement stated that each spouse waived all rights to the other's insurance policies. In 2026, Daniel submitted a request to the insurer to change the beneficiary to his daughter and take out a policy loan, without attaching any form signed by Sofia. How will the insurer respond?

a. Approve both requests, because a finalized divorce automatically converts an irrevocable spouse beneficiary into a revocable one.

b. Approve both requests once Daniel sends a copy of the divorce agreement, because the general waiver clause binds the insurer.

c. Reject the beneficiary change, but approve the policy loan because borrowing cash value is an unrestricted right of the policyholder.

d. Refuse both the beneficiary change and the policy loan until Sofia signs a written consent or release that is delivered to the insurer's head office.

200′. Maya bought a $500,000 life insurance policy and checked the 'irrevocable beneficiary' box naming her sister on a separate declaration form, but Maya kept the signed form in her home safe and never sent it to the insurer's head office. Two years later, Maya sent a new written notice to the insurer's head office naming her brother as beneficiary instead. Does Maya need her sister's consent to make this change?

a. Yes, because an irrevocable designation becomes permanently binding the moment the policyholder signs the declaration.

b. No, because an irrevocable designation only takes effect as irrevocable once it is delivered to the insurer's head office.

c. Yes, because siblings belong to the preferred family beneficiary class, which locks in the policy automatically.

d. No, because a sister cannot legally be named as an irrevocable beneficiary under a personal life insurance contract.

201. Ethan held a $500,000 individual life insurance policy for 6 years before missing a premium payment. He still did not pay during the 30-day grace period, nor during the 30 days after the grace period ended, causing the policy to remain lapsed. Six months later, Ethan applied for reinstatement, paid all overdue premiums with interest, provided satisfactory evidence of insurability, and the policy was reinstated. One year after the reinstatement date, Ethan died by suicide. Under the standard exam rule for the suicide clause, how will the insurer handle the claim?

a. Pay the $500,000 death benefit in full, because the policy had already been in force for 6 years before the lapse occurred.
b. Deny the $500,000 death benefit, because reinstatement restarts the 2-year suicide exclusion period from the date of reinstatement.
c. Pay half of the $500,000 death benefit, because the suicide occurred halfway through the restarted 2-year exclusion period.
d. Deny the claim because any history of policy lapse permanently excludes death by suicide for the remainder of the contract.

201′. Ava missed her monthly premium due date on her $500,000 term life insurance policy. Fifteen days after the due date, while the premium was still unpaid, Ava died in a traffic accident. How will the insurer settle the claim?

a. Pay the $500,000 death benefit minus the overdue premium, because the policy remained in force during the 30-day grace period.
b. Deny the claim completely, because insurance coverage suspends on the premium due date until the overdue payment is received.
c. Pay the full $500,000 without deducting the overdue premium, because the grace period waives any premium due in the month of death.
d. Require the beneficiary to submit satisfactory medical evidence of Ava's insurability before releasing the death benefit.

202. Claire owns a $500,000 permanent life insurance policy on which her mother is properly designated as the irrevocable beneficiary. Claire wants to borrow $180,000 from a bank for her small business, and the bank requires a collateral assignment of the policy as security. According to the standard LLQP exam rule, what must happen for Claire to pledge the policy and give the bank priority for the unpaid loan balance upon her death?

a. Claire can complete the collateral assignment and grant the bank first priority without her mother's consent because a loan pledge is not a sale.
b. Claire must execute an absolute assignment to the bank, which automatically extinguishes her mother's irrevocable beneficiary status.
c. Claire must obtain her mother's written consent to the collateral assignment and deliver the assignment and consent to the insurer.
d. The policy cannot be used as loan security under any circumstances once an irrevocable beneficiary has been named.

202′. Following up on a valid collateral assignment where the irrevocable beneficiary gave written consent for a $180,000 bank loan against a $500,000 life insurance policy, the policyholder dies when the remaining loan balance is $120,000. How will the insurer distribute the $500,000 death benefit?

a. Pay the entire $500,000 to the bank, because a collateral assignment transfers full ownership of the death benefit to the lender.
b. Pay $180,000 to the bank based on the original loan principal and $320,000 to the beneficiary.
c. Pay the entire $500,000 to the irrevocable beneficiary, leaving the bank to sue the policyholder's estate for the $120,000.
d. Pay $120,000 to the bank to settle the unpaid loan balance and pay the remaining $380,000 to the beneficiary.

203. Arthur owns a $500,000 life insurance policy on his own life and has significant personal business debts. He tells his agent that he wants to change his beneficiary designation from his wife to 'my estate' so that the insurance proceeds will be distributed together with his other assets under his will. What is the legal consequence if Arthur names his estate as beneficiary?

a. The policy loses its preferred–beneficiary exemption; at death the proceeds fall into the estate, attract probate fees and are open to his creditors.
b. The proceeds remain exempt from Arthur's creditors as long as his will ultimately leaves the estate residue to his wife and children.
c. The insurer will refuse the change because a policyholder is legally prohibited from naming their own estate on an individual policy.
d. The proceeds will bypass probate fees because life insurance payouts are always tax–free and probate–free regardless of who is named.

203′. A corporation purchases a $750,000 life insurance policy on the life of its key shareholder, naming the corporation itself (the policyholder) as the recipient of the death benefit. Meanwhile, the shareholder owns a personal $500,000 policy on his own life naming his daughter as revocable beneficiary. If both the corporation and the shareholder face creditor claims while the shareholder is alive, which policy enjoys lifetime protection from seizure by the policyholder's creditors?

a. Both policies, because any life insurance policy with a named recipient is exempt from seizure during the insured's lifetime.
b. Only the shareholder's policy, since his daughter is a family–class beneficiary, while the corporation collects only as policyholder.
c. Only the corporate policy, because commercial insurance policies receive automatic statutory creditor immunity under the Insurance Act.
d. Neither policy, because lifetime exemption from seizure applies only when a beneficiary is designated irrevocably.

Chapter 30 · Claims and Payment of Proceeds Ethics & Professional Practice

Items marked ′ are variants on the same point: do one when you miss the main question.

204. An insured with a $500,000 life insurance policy died two years ago. Upon receiving reliable notice of death from the insured's employer, the insurer recorded the death and stopped billing premiums, but did not reach out to the named beneficiary, who was unaware of the policy. Today, the beneficiary discovers the policy and submits the death certificate, proof of the insured's age, proof of the claimant's right to receive payment, and proof of the beneficiary's name and age. Under the exam rules and the BC Insurance Act, how do the notification rules and the two time clocks apply?

a. The insurer breached its statutory duty by not notifying the beneficiary two years ago, and the 30–day payment clock expired 30 days after the date of death.

b. The insurer had no duty to notify her; with all four proofs now in, it must pay within 30 days, and any suit must start within the earlier of 2 years after proof or 6 years after death.

c. The claim is barred because notice and proof of a life insurance claim must always be submitted within 30 days and 90 days of death respectively.

d. Because filing a life insurance claim itself has no fixed statutory deadline, the beneficiary has an unlimited number of years to sue the insurer in court if payment is refused.

204′. Following the death of an insured under a $300,000 term life policy, the named beneficiary promptly submits a funeral director's statement of death and her own photo identification, but has not yet provided satisfactory proof of the insured's age or proof of her right as claimant. When does the insurer's 30–day statutory payment period begin, and what governs the deadline to sue the insurer?

a. The 30–day payment period began on the date the funeral director's statement was submitted, because a death statement alone constitutes complete proof of claim.

b. The insurer must pay within 60 days of receiving the initial notice of claim, and the beneficiary has 6 years from the date of proof to start legal action.

c. Because the insurer has not yet received all four items of proof, it must immediately pay the $300,000 into court under section 82 within 15 days.

d. The section 73 clock starts only once all four elements of proof are received; any lawsuit is limited to the earlier of 2 years after proof or 6 years after death.

205. An insured with a $300,000 term life policy disappears while hiking alone. His spouse, the named beneficiary, asks her insurance agent how long a person must generally be missing before the family can petition a court for a presumption of death under standard exam rules, whether there are exceptions when a person disappears in a confirmed air disaster, and whether she should keep paying premiums in the meantime. What is the correct exam answer?

a. She must wait 7 years in all circumstances without exception, and she can safely stop paying premiums immediately because disappearance freezes the policy.
b. She must wait 2 years under the incontestability rule, and if the policy lapses, the court declaration of death automatically reinstates the policy retroactively.
c. Generally 7 years of absence, unless strong evidence such as an air crash allows an earlier ruling; she should keep paying premiums so the policy does not lapse.
d. She must wait 6 years under the limitation period, and the insurer is required to waive all premiums as soon as a missing-person police report is filed.

205′. A passenger insured under a $500,000 life insurance policy was on board a commercial flight that crashed into the ocean with no survivors, though his body was never recovered. Once a court issues an order declaring a presumption of death, how do the waiting period rule and the BC statutory limitation period under section 76(2) apply?

a. The crash evidence lets the court declare death without waiting the 7-year general period, and the limitation period runs 2 years from the court's declaration.
b. The family must still wait 7 years before petitioning the court because no body was recovered, and they have 6 years after the declaration to sue.
c. The insurer can refuse to accept the court order as proof of death until 7 years have elapsed from the crash date.
d. The court order automatically pays the $500,000 within 15 days, and there is no limitation period once a presumption of death is granted.

206. Upon the death of an insured with a $250,000 life policy, the insurer's head office records show his former spouse as the revocable beneficiary. Before any payment is made, the insured's current spouse presents a valid will signed recently that designates the current spouse as beneficiary of the policy, and both spouses hire lawyers to demand the $250,000. The insurer acknowledges that the $250,000 is payable. What is the appropriate course of action for the insurer and the agent?

a. The agent reports the conflicting claims to the insurer without taking sides, and the insurer may apply under section 82 to pay the $250,000 into court.
b. The insurer can apply to pay the money into court under section 82 in order to deny liability and cancel the $250,000 policy.
c. Because a beneficiary designation in a will is always invalid in BC, the agent should advise the current spouse to drop the claim immediately.
d. Even after receiving the will and the lawyer's demand at its head office, the insurer is required by section 77 to pay the former spouse and ignore the will.

206′. An insured changed the beneficiary of his $250,000 life insurance policy in a signed document kept in his desk drawer, shifting the benefit from his brother to his sister, but the document was never sent to the insurer. After the insured died, the brother submitted complete proof of claim and the insurer paid the $250,000 to the brother within 30 days before learning of the document in the drawer. Later, the sister sends the document to the insurer's head office and demands payment from the insurer. Under section 77 of the BC Insurance Act, what is the insurer's legal position?

a. The insurer must pay a second $250,000 to the sister because the signed document took effect the moment the insured placed it in his drawer.
b. The insurer must apply for a declaration as to sufficiency of proof under section 78 to determine whether the brother's age was properly verified.
c. The insurer is discharged to the extent of the $250,000 paid, because it paid the brother per its records before head office received the document.
d. The insurer is penalized by the Insurance Council of BC for failing to search the insured's home desk before releasing the funds.

207. An insured and his wife, who is the sole named primary beneficiary on his $500,000 life insurance policy, die together in an accident where it is impossible to determine who died first. The policy contains no special survivorship clause and names no contingent beneficiary. Under both the exam general rule and section 83 of the BC Insurance Act, how is the $500,000 life insurance benefit distributed, and how does BC's five-day survival rule under WESA apply to the policy?

a. The younger spouse is presumed to have survived the older spouse, so the $500,000 goes to the wife's estate if she was younger.
b. WESA's five-day survival rule governs the life insurance policy, splitting the $500,000 equally between the insured's estate and the wife's estate.
c. The insured is deemed to have died first, so the $500,000 passes to the wife's estate and becomes subject to her will.
d. The wife is deemed to have died first under section 83, so the $500,000 goes to the insured's estate; WESA's five-day rule does not apply to insurance money.

207′. A policyowner insured his own life for $300,000 and named his three adult children in equal shares as primary beneficiaries, with no contingent beneficiary and no special policy provision. One of the three children died two years before the policyowner. When the policyowner dies today, how is the $300,000 death benefit distributed under section 63 of the BC Insurance Act and the exam rules?

a. The deceased child's one-third share passes into that deceased child's own estate, while the two surviving children each receive one-third.
b. The deceased child's share goes to the two surviving beneficiaries in equal shares, so the two surviving children divide the $300,000 equally.
c. The deceased child's one-third share reverts to the policyowner's estate, while the two surviving children still take only one-third each.
d. The entire $300,000 must be paid into court under section 82 because the death of a beneficiary invalidates the entire beneficiary designation.

208. An individual Accident and Sickness (A&S) policyowner suffers a disabling injury. Under the statutory conditions in BC, within how many days must the claimant give written notice of claim, within how many days must the insurer furnish forms for proof of claim, within how many days must the claimant submit proof of claim, and how does the payment deadline for an initial loss-of-time benefit in BC compare with the general exam rule?

a. Notice within 15 days, forms within 30 days, proof within 60 days; both the exam rule and BC law require all A&S benefits to be paid within 30 days.
b. Notice 30 days, forms 15 days, proof 90 days; the exam rule says 60 days to pay, but BC requires the first loss-of-time payment within 30 days.
c. Notice within 30 days, forms within 30 days, proof within 90 days; group A&S and individual A&S share the exact same mandatory 60-day statutory payment rule without exception.
d. There are no statutory deadlines for notice or proof in individual A&S, and the insurer is barred from requesting updated Attending Physician's Statements (APS) once the first payment is made.

208′. A claimant has been receiving ongoing disability income (loss of time) benefits under an individual A&S policy after receiving the first payment within 30 days. During the ongoing benefit period, the insurer requests an updated Attending Physician's Statement (APS) and a medical examination, and the claimant also asks her agent what the statutory payment deadline would be if she had instead been covered under an employer's group A&S contract. Which explanation is accurate?

a. Disability claims are paid and reviewed on an ongoing basis, so exams and updated APS forms may be required; group A&S payment timing follows the group contract.
b. Once the initial 30-day payment is made, the insurer loses the right to request any further APS forms for at least 2 years under the incontestability rule.
c. Group A&S policies are strictly bound by a statutory 15-day payment deadline under the BC Insurance Act.
d. A claimant under a non-death A&S claim has 6 years from the date she knew or ought to have known of the claim to sue the insurer.

209. An insured with a $500,000 life insurance policy is killed in a criminal assault committed by his brother. The brother had no intention of profiting from the policy and did not even know that he was named as one of the two equal primary beneficiaries on the policy. Under the public order rule on the exam, how must the insurer handle the claim?

a. Refuse the brother's share, as one who criminally causes the death is barred whatever his motive or knowledge; the policy stays valid for the co-beneficiary.

b. The insurer must pay the brother his share because he did not know he was a beneficiary and therefore did not commit insurance fraud.

c. The entire $500,000 policy is automatically voided from inception, so the innocent co-beneficiary and the estate receive nothing at all.

d. Because the policy had been in force for more than 2 years, the incontestability period forces the insurer to pay the brother his full share.

209′. An insured bought a $300,000 life insurance policy 3 years ago. The policy later lapsed for non-payment after the 30-day grace period and was formally reinstated within the past year. Today, within 2 years of reinstatement, the insured dies by suicide. While reviewing the claim, the beneficiary's lawyer also asks how the 2-year incontestability rule treats two kinds of application errors in general: an innocent mistake about family history, and a deliberate concealment of a serious condition. Under the BC Insurance Act, how do the suicide clause and the 2-year incontestability rule apply?

a. Suicide clauses are unenforceable under BC law, and once 2 years have passed the insurer cannot contest either an innocent mistake or fraud.

b. The 2-year suicide exclusion period never resets upon reinstatement, so suicide within 2 years after reinstatement must be paid.

c. After 2 years from initial issue, an innocent non-disclosure makes a contract voidable, whereas deliberate fraud becomes protected by section 52.

d. Suicide within 2 years of reinstatement is excluded, as the clause runs from issue or reinstatement; after 2 years, s.52 protects innocent errors but never fraud.

210. An insured in BC dies leaving a $250,000 life insurance policy naming his young minor nephew (under age 18) as beneficiary without appointing a trustee for the funds, and another $250,000 policy naming his 18–year–old daughter as beneficiary. How does the general exam rule describe the payment of insurance proceeds to a minor when no trustee is appointed, and how does section 88 of the BC Insurance Act specifically handle the payments to the minor nephew and the 18–year–old daughter?

a. In both cases, the insurer automatically pays each $250,000 directly to the child's surviving parent, with no trust and no distinction by age.
b. Neither beneficiary can give a valid discharge at age 18 in BC, so both $250,000 payments must be forfeited to the insurer.
c. Exam: some provinces require payment into court. BC s.88: the nephew's share goes in trust to the Public Guardian and Trustee; the daughter, 18, is paid directly.
d. Both the minor nephew and the 18–year–old daughter are disqualified as beneficiaries, because minors cannot be named on life insurance policies at all.

210′. An individual holds two contracts: a regular life insurance policy and a locked–in retirement plan funded from a pension plan. On both contracts, he designated his adult brother as beneficiary, even though he has a qualifying spouse who has not waived her statutory entitlement. When the individual dies, who has priority to receive the death benefits from the two contracts?

a. The qualifying spouse automatically overrides the named beneficiary on both the regular life insurance policy and the pension–derived plan.
b. The brother takes the regular life policy as named beneficiary, but on the pension–derived plan the qualifying spouse has statutory priority.
c. The adult brother receives the payouts from both contracts in a lump–sum check because a beneficiary designation always overrides pension legislation.
d. Both contracts must be paid to the Public Guardian and Trustee under section 88 because a brother is not a spouse.

Chapter 31 · Bodies That Protect the Client Ethics & Professional Practice

Items marked ′ are variants on the same point: do one when you miss the main question.

211. Marcus, a life insurance agent in Kelowna, discovers that a competitor has been persuading clients to replace their policies using fabricated illustrations. Meanwhile, one of Marcus's clients asks which regulator verifies that federally registered life insurers maintain enough capital to pay future claims. Which pair of bodies is responsible for investigating the competitor's misconduct and monitoring the federal insurer's financial soundness?

a. The Insurance Council of BC handles the agent's misconduct; OSFI monitors the insurer's financial soundness.
b. OSFI investigates both the agent's misconduct and the federal insurer's financial soundness.
c. BCFSA disciplines the individual agent, and Assuris audits the federal insurer's capital reserves.
d. OLHI revokes the competitor's licence, and the CCIR audits the federal insurer's solvency.

211′. A federally registered life insurance company operating in Vancouver faces questions about its capital adequacy, while one of its local commissioned agents is accused of forging a client's signature on an application. How is regulatory jurisdiction divided between federal and provincial authorities in this situation?

a. OSFI handles both the insurer's capital adequacy and the disciplinary hearing to revoke the agent's provincial licence.
b. The Insurance Council of British Columbia evaluates the federal insurer's capital reserves, while BCFSA revokes the agent's licence.
c. OSFI oversees the insurer's financial soundness, while the Insurance Council of BC handles the disciplinary case against the agent.
d. CISRO oversees the federal insurer's capital adequacy, while OLHI imposes a fine on the agent for forgery.

212. An agent in Burnaby offers to refund part of his first-year commission to a prospective client if the client agrees to purchase a universal life policy, and also tells the client that a mortgage renewal depends on buying the policy. Under British Columbia law, which statute contains the specific provisions prohibiting premium rebating, prohibiting tied selling, and governing the licensing and penalties of insurance agents?

a. The Insurance Act of British Columbia, which contains a dedicated chapter governing insurance agents and market conduct offences.
b. The Financial Institutions Act of British Columbia, which sets out rules on rebating, tied selling, licensing of agents, and offences.
c. The federal Insurance Companies Act, which regulates provincial agent commission rebates and licensing across all common-law provinces.
d. The Personal Information Protection Act of British Columbia, which governs unfair trade practices and agent licensing requirements.

212′. A newly licensed advisor in Surrey is reviewing the statutory rules in British Columbia that govern insurance contracts versus the rules that govern the licensing and conduct of insurance agents. Which statement accurately reflects how British Columbia legislation divides these topics?

a. The Insurance Act has no specific chapter on agents; statutory provisions governing agents, rebating, and tied selling are in the Financial Institutions Act.
b. The Financial Institutions Act governs beneficiary designations and incontestability, while the Insurance Act governs agent licensing and rebating.
c. Both contract law rules and agent licensing rules are consolidated solely within the British Columbia Insurance Act.
d. Contract rules are governed by the provincial Insurance Act, whereas agent licensing and rebating rules are governed by the federal PCMLTFA.

213. Elena holds a permanent life insurance policy with a $500,000 death benefit and a $60,000 cash value. If her insurer becomes insolvent, what is the role of the liquidator first, and based on the LLQP exam manual table (TABLE 4.1), what minimum death benefit protection does Assuris provide if benefits must be reduced?

a. The liquidator immediately cancels all policies and pays cash; Assuris protects $200,000 of the death benefit because the lower threshold applies.
b. The liquidator first tries to transfer the policies; if benefits are cut, the exam table protects $425,000 of the death benefit.
c. The liquidator transfers the policy only if Elena paid an Assuris membership fee; otherwise Assuris protects only $75,000 of the death benefit.
d. The liquidator merges the insurer with OSFI; Assuris pays Elena both the $200,000 floor plus 85% ($425,000) of the death benefit combined.

213′. David owns policies with a life and health insurer that becomes insolvent, and the liquidator cannot transfer the policies without reducing benefits. According to the LLQP exam manual table (TABLE 4.1), what are the base dollar thresholds (before comparing with the 85% proportional protection) for monthly income, health expense, and cash value benefits under Assuris?

a. $2,000/month for monthly income, $100,000 for health expense, and $200,000 for cash value, or 85% of promised benefits, whichever is lower.
b. $5,000/month for monthly income, $250,000 for health expense, and $100,000 for cash value, with policyowners required to apply within 90 days.
c. $2,000/month for monthly income, $60,000 for health expense, and $60,000 for cash value, only if the policyowner paid an extra Assuris premium.
d. $2,000/month for monthly income, $60,000 for health expense, and $60,000 for cash value (or 85% of promised benefits, whichever is higher), covered automatically.

214. To pay the initial deposit on an annuity contract, a client brings $9,000 in cash to his life insurance agent on Tuesday afternoon and brings another $9,000 in cash for the same contract on Wednesday morning, within a single 24-hour window. The client's explanation for using $18,000 in cash is consistent with his business, and there are no grounds to suspect money laundering. What are the reporting obligation and submission deadline under FINTRAC rules?

a. No report is required because neither individual $9,000 cash payment reached the $10,000 single-transaction threshold.
b. A Large Cash Transaction Report (LCTR) must be submitted within 24 hours of receiving the second cash payment.
c. A Large Cash Transaction Report (LCTR) is triggered under the 24-hour rule and must be submitted within 15 calendar days.
d. A Suspicious Transaction Report (STR) must be submitted within 5 business days solely because the $18,000 cash was split into two payments.

214′. During a meeting with a prospective client in Kamloops, a life insurance agent gathers facts that give rise to reasonable grounds to suspect that the proposed universal life transaction is linked to the laundering of illicit proceeds, even though the initial cheque is under the $10,000 threshold at $9,000. Under FINTRAC rules, what report is required and when must it be submitted?

a. No report is required because the transaction is under $10,000 and is paid by cheque rather than cash.
b. A Suspicious Transaction Report (STR), sent as soon as practicable once reasonable grounds to suspect are established.
c. A Suspicious Transaction Report (STR) must be submitted within 15 calendar days of the client meeting.
d. An Electronic Funds Transfer Report (EFTR) must be submitted within 24 hours to the Insurance Council of British Columbia.

215. After a dispute over the conversion privilege on his term life policy, a client in Nanaimo receives a final position letter from the insurer's internal complaints department rejecting his request. He wants an independent review of the contract dispute, and he also wants the agent who sold him the policy disciplined for failing to disclose a conflict of interest. Which bodies handle these two requests?

a. OLHI reviews the contract dispute now that he holds a final position letter, and the Insurance Council of BC handles the discipline.

b. OLHI adjudicates both the contract dispute and the suspension of the agent's licence because it is the national ombudservice.

c. The Insurance Council of British Columbia orders the insurer to honour the conversion privilege and also fines the agent.

d. The Financial Consumer Agency of Canada (FCAC) mediates the policy conversion dispute, while CISRO revokes the agent's licence.

215′. A policyholder in Prince George is unhappy with how her disability claim is being handled by her insurer's claims examiner. Without contacting the insurer's internal complaints department, she immediately calls the OmbudService for Life and Health Insurance (OLHI) and demands that OLHI fine the insurer and award her damages. Why will OLHI not proceed with her demand?

a. OLHI only accepts complaints that are referred to it by OSFI, the federal solvency regulator.

b. OLHI only handles property and casualty insurance disputes, whereas life and health disputes go to PACICC.

c. She must first finish the insurer's internal process and get a final position letter, and OLHI has no power to fine anyone.

d. OLHI can impose statutory fines on the insurer, but only after a 120-day waiting period set by the Insurance Act.

216. An independent life insurance agency operates exclusively within British Columbia, collecting and storing personal information from local residents for life insurance applications. However, the agency recently started transferring commercial client data across provincial borders to an affiliate in Ontario. How do privacy laws apply to the agency's activities?

a. Only the federal PIPEDA applies to all of the agency's activities because British Columbia has not enacted private-sector privacy legislation.

b. Only British Columbia's FOIPPA applies to the agency, enforced by the Insurance Council of British Columbia.

c. Neither PIPEDA nor PIPA applies because federal Bill C-36 has already repealed both statutes for insurance intermediaries.

d. PIPA generally governs its activities within BC, while PIPEDA may apply to commercial personal information sent across provincial borders.

216′. A life insurance advisor practising only in Coquitlam asks her compliance officer why the office privacy manual cites BC's Personal Information Protection Act (PIPA) rather than relying solely on federal PIPEDA. Which explanation is accurate?

a. BC has its own private-sector privacy law, PIPA, deemed substantially similar to PIPEDA, so activity within BC generally falls under PIPA.

b. PIPEDA applies only to banks and telecommunications companies, and never applies to any insurance transactions anywhere in Canada.

c. PIPA is a federal statute administered by FINTRAC specifically for life insurance agents across Canada.

d. PIPEDA was repealed in 2019, at the same time that BCFSA replaced FICOM in British Columbia.

217. An experienced life insurance agent in Abbotsford lets his errors and omissions (E&O) insurance lapse and fails to notify the regulator within 5 business days, and also falsely declares on his annual licence renewal that he completed the required continuing education (CE) credits. Under the rules of the Insurance Council of British Columbia, what are the minimum E&O limits, the annual CE requirement, and the consequence of these breaches?

a. Minimum E&O of $500,000 per claim, 24 CE credits per year, and automatic compensation paid by Assuris to affected clients.

b. Minimum E&O of $2,000,000 per claim, 5 CE credits per year, and a disciplinary fine imposed by OLHI.

c. Minimum E&O of $1,000,000 per claim and $2,000,000 aggregate, 15 CE credits per licence year, and Council discipline.

d. Minimum E&O of $1,000,000 aggregate, 15 CE credits every two years, and licence revocation by OSFI.

217′. A life insurance agent in Victoria is retiring from the industry and asks about her errors and omissions (E&O) insurance and continuing education (CE) record-keeping obligations under the Insurance Council of British Columbia rules. Which statement accurately describes her obligations and coverage?

a. E&O insurance covers both negligent errors and intentional fraud, and CE records only need to be kept until the June 1 renewal date.

b. Run-off E&O covers claims from acts while she was licensed, and active licensees must keep CE records for 5 licence periods.

c. Once she retires before July 31, Assuris automatically assumes her E&O liability for past sales advice.

d. She must maintain $1,000,000 per claim E&O through CISRO, which audits BC agents' CE records every two years.

Chapter 32 · Main Responsibilities of Life Insurance Agents

Ethics & Professional Practice

Items marked ′ are variants on the same point: do one when you miss the main question.

218. Tariq, a life insurance agent, sets up a non-exempt universal life insurance policy for a new individual client, Mei. Mei will pay an annual premium of $2,000, and the policy is expected to remain in force for at least 15 years. Mei offers to show her personal credit card and a signed personal cheque to verify her identity, arguing that her first payment is well below $10,000. How must Tariq proceed under FINTRAC client identification rules?

a. He must verify her identity within 30 days of creating the information record, using an approved method such as government photo ID.

b. He can wait until the fifth policy anniversary when Mei's cumulative premium payments actually reach $10,000 before verifying her identity.

c. He can accept Mei's personal credit card and signed cheque right away because inspecting two financial instruments in person satisfies the dual-process method.

d. He does not need to verify Mei's identity at all, but he must verify the beneficiary's identity on the day the policy application is signed.

218′. Nadia is purchasing a non-registered annuity from agent Victor with quarterly deposits of $2,000 over a 3-year schedule. When Victor asks for identification, Nadia presents a municipal recreation pass with her photo and says verification is unnecessary anyway since each deposit is only $2,000. What is Victor's obligation?

a. Accept the municipal photo pass because any government level, including a city, can issue qualifying photo identification.

b. Skip identity verification because non-registered annuities are treated the same as TFSA and RRSP contracts under FINTRAC rules.

c. Reject the municipal pass and use an approved method within 30 days of creating the record, since total deposits will exceed $10,000.

d. Accept a photocopy of a 3-year credit file that Nadia printed at home last month as single-source credit verification.

219. Chloe recommends that her client, Sam, cancel an existing whole life policy to purchase a new universal life policy with higher coverage. Sam agrees with the idea but tells Chloe he is leaving for the airport in 20 minutes for a vacation and asks to sign a blank form now without going over the written comparison or the Life Insurance Replacement Declaration (LIRD). What must Chloe do?

a. Have Sam sign the application now and email him a general explanation letter after he returns from vacation instead of completing the LIRD.

b. Complete the LIRD and written comparison, go through risks, cash value and tax effects with Sam, and leave copies with him and the insurer.

c. Skip the LIRD because Sam is upgrading his coverage amount rather than reducing his death benefit.

d. Omit the discussion of inherent risks and tax consequences so Sam does not change his mind before his flight.

219′. Agent Owen suggests that his long-time client, Paula, surrender the cash value of her existing life insurance policy at Company X to fund a new policy at the same insurer, Company X. Because the transaction stays within the same insurance company and Paula trusts him completely, Owen wonders if he still needs to prepare a Life Insurance Replacement Declaration (LIRD) and written comparison. What is the rule?

a. No LIRD is required when the existing policy and the new policy are issued by the same insurance company.

b. No written comparison is required because Paula is a long-time client who already gave verbal consent.

c. Owen only needs to disclose the commission he will earn under CLHIA Guideline G19 instead of completing a LIRD.

d. Both are still required for a same-insurer replacement, and Owen must go through them with Paula and give her copies.

220. Agent Liam meets a young couple who say they want a 20-year term life policy. Without conducting a fact-finding interview, documenting a needs analysis, or preparing a written explanation of his recommendation, Liam immediately submits the application for the 20-year term policy, which happens to fit their budget and mortgage. When the policy is issued two weeks later, Liam arrives to deliver it and learns that the husband was hospitalized yesterday for a serious cardiac condition. Which statement accurately describes Liam's compliance status?

a. Liam complied with suitability rules because the 20-year term policy objectively matched their mortgage, and he can still deliver the policy since underwriting was already approved.

b. Liam satisfied suitability rules by following the couple's request, and he only needs to note the hospitalization in his complaint log after handing over the policy.

c. He already breached needs-based selling by skipping fact-finding and records, and must now hold the policy and send the new health facts to the insurer.

d. Liam can cure both issues by having his E&O insurer guarantee the husband's cardiac claim at the time of delivery.

220′. Sonia, a life insurance agent, follows the industry best-practice sequence when meeting a new client. After making initial disclosures and learning the client's expectations, she wants to jump straight to recommending a product and writing a reason-why letter without gathering all facts or assessing needs. What happens if she skips those middle steps?

a. It breaches needs-based sales practice, even if the product she picks turns out to suit the client.

b. Skipping fact-finding is acceptable as long as the reason-why letter serves as proof that the insurer has completed underwriting.

c. The Ethics module requires using the exact title 'Reason-Why Letter' on the form, which automatically waives the fact-finding step.

d. She only needs to complete fact-finding if the policy premium exceeds $10,000 over its duration.

221. Brendan, a life insurance agent in BC, lets his Errors and Omissions (E&O) insurance policy lapse on May 1. He assumes that because the automatic licence suspension rule mentions 30 calendar days, he has a 30-day grace period to keep selling policies without E&O coverage and without telling the Insurance Council of BC. In addition, a former client sues him for forging a signature on a beneficiary change form last year. Which statement correctly applies the rules to Brendan's situation?

a. Brendan can rely on the 30-day period as an uninsured practice grace period, and his prior E&O policy will pay damages for the forged signature up to $1,000,000 per claim.
b. Brendan only needs to notify the Council if his E&O lapse lasts longer than 30 calendar days, though forgery is excluded from E&O coverage.
c. Brendan's E&O policy covers intentional forgery up to the $2,000,000 aggregate limit, provided he purchases run-off insurance within 5 business days.
d. The 30 days are not a grace period: he must notify the Council within 5 business days, carry $1,000,000/$2,000,000 limits, and E&O excludes forgery.

221′. After 25 years as a licensed life insurance agent in BC, Farah is retiring next month and surrendering her licence. She kept continuous E&O coverage of $1,000,000 per claim and $2,000,000 aggregate while active, and she never committed fraud or forgery. However, she worries a client might file a negligence claim two years after her retirement regarding advice she gave last year. What should Farah arrange before retiring?

a. She needs no further protection because the Insurance Council of BC automatically pays negligence claims made against retired agents.
b. She should arrange run-off insurance to extend E&O protection for claims arising after retirement from her prior years of practice.
c. She should destroy all client files and needs-analysis records on her retirement day so no evidence exists for future disputes.
d. She can rely on the 30-calendar-day automatic suspension window to cover claims for the next two years.

222. In a standard national LLQP exam question based on the general exam rules, an agent offers to give a prospective client a portion of the first-year commission back in cash just to persuade the client to sign a policy the client does not really need. Meanwhile, the agent also wants to share a portion of his commission with a colleague. How is the cash inducement classified under the national exam rules, and when is commission sharing allowed?

a. Rebating to induce an unsuitable purchase is an unfair practice, and commissions may be shared only with a properly licensed agent, with disclosure.
b. Premium rebating of any percentage is unconditionally legal across Canada under CLHIA Guideline G19, and commissions can be split directly with unlicensed friends.
c. Sharing commissions with an unlicensed person is allowed if the unlicensed person conducts the needs analysis and explains the policy terms.
d. The agent can promise future renewal-year rebates to lock in the sale without checking suitability or insurer contract rules.

222′. Derek holds only a general insurance licence in BC and is not licensed for life insurance. He refers a client to Maya, a licensed life insurance agent, without discussing insurance needs or product features with the client. Maya wants to pay Derek a referral fee. Under BC rules discussed in the lecture, under what condition can Maya pay this referral compensation?

a. Maya can split her life insurance commission with Derek without disclosure because any insurance licence counts as being licensed for life insurance.
b. Maya cannot pay any referral fee to Derek unless CLHIA Guideline G19 is cited in the client's policy contract.
c. She can pay it, since Derek did no insurance activity such as discussing needs, if the fee is disclosed in writing before the transaction.
d. Derek is allowed to complete the client's needs analysis and LIRD form as long as his contract with Maya calls the payment a 'referral fee.'

223. Agent Kevin convinces his client, Elena, to cancel her 3-year-old $150,000 term life policy with Insurer Alpha and buy a new policy with Insurer Beta so Kevin can earn a high first-year commission. While persuading her, Kevin hides the surrender costs and new contestability period, and he also posts on social media that Insurer Alpha is 'slow to pay claims and mistreats every policyholder.' Which two unfair or deceptive practices has Kevin committed?

a. Churning and fronting.
b. Twisting and defamation.
c. Tied selling and trafficking in insurance.
d. Churning and holding out improperly.

223′. Agent Valerie repeatedly persuades her existing clients at Insurer Gamma to replace their perfectly suitable Gamma policies with brand-new Gamma policies every two years, solely so Valerie can collect fresh first-year commissions and qualify for a company bonus. What specific prohibited practice is Valerie committing?

a. Churning, because she induces needless replacements within the same insurer to earn new commissions.
b. Twisting, because any policy replacement motivated by commission is called twisting regardless of the insurer.
c. Fronting, because she is submitting multiple applications under her own licence.
d. Tied selling, because she links her bonus to the new policies.

224. When filing her annual licence renewal declaration with the Insurance Council of BC, agent Serena checks the box confirming that she has completed all required Continuing Education (CE) credits for the licensing period, even though she is actually short by 2 credits. Two months later, a Council audit uncovers the shortfall. Based on the real Insurance Council of BC disciplinary decisions in the lecture, what consequence can Serena face under the Financial Institutions Act and Council Rules?

a. No fine or course can be imposed because a CE shortfall of 2 credits is a minor administrative oversight rather than criminal forgery.
b. Her E&O insurance carrier will pay the fine and complete the missing credits on her behalf.
c. A $500 fine, required courses, making up the 2 missing credits, and no new licence application accepted until she complies.
d. The Council can discipline her immediately without giving her written notice or an opportunity to be heard under the Financial Institutions Act.

224′. Agent Patrick forgets to renew his E&O insurance and fails to notify the Insurance Council of BC within 5 business days of the lapse. Based on the real disciplinary decision involving Sahar Rezaei in the lecture, which combination of disciplinary orders can the Council impose on Patrick under the Financial Institutions Act?

a. A $500 fine, $950 in costs, two required courses, and automatic suspension with renewal limits if he misses the deadline.
b. Only a verbal reminder, because the 5-business-day notification rule is merely a voluntary guideline with no financial penalty.
c. Automatic permanent criminal conviction under the Criminal Code, because E&O lapses are treated the same as forgery.
d. No penalty at all, as long as no client filed a claim during the days he lacked E&O coverage.

Answers and option–by–option reasons

Chapter 1 answers and reasons

1 answer a

a. ✓ Correct. The six categories of financial impacts of death often arise simultaneously: in addition to the loss of income caused by Marcus's death, being the sole parent caring for young children at home also creates a loss of caregiver (requiring paid help to care for the children), plus debt repayment for the mortgage and estate creation to secure the children's university education fund. Needs analysis must examine and sum each category.

b. ✗ Falls into the 'category omission (counting lost salary while overlooking lost caregiving)' trap. A single parent is both the sole earner and the sole adult caring for young children at home; death simultaneously triggers loss of income and loss of caregiver, while also omitting the estate creation needed for the education fund.

c. ✗ Falls into the 'category omission and debt rule misunderstanding' trap. The estate executor must complete debt repayment before distributing the estate; lenders never automatically forgive a mortgage due to the borrower's death, and this option also omits the loss of caregiver.

d. ✗ Falls into the 'concept confusion' trap. Marcus is an employed logistics manager rather than a business owner or qualified farm or fishing partner; business impacts and the Lifetime Capital Gains Exemption (LCGE) do not apply.

1′ answer c

a. ✗ Falls into the 'category omission (counting lost salary while overlooking lost caregiving)' trap. Mistakenly equates having no earned income with having no economic value, ignoring the substantial replacement labor costs incurred when a full–time caregiver dies.

b. ✗ Falls into the 'concept confusion' trap. An employed pharmacist's employment contract is not capital property or corporate shares, and does not trigger business impacts or deemed disposition upon the spouse's death.

c. ✓ Correct. The death of Sam as a stay–at–home caregiver with no earned income directly triggers a loss of caregiver; Elena must pay out of pocket to hire replacement care for their young daughter and frail relative, while the household still faces debt repayment obligations such as the mortgage.

d. ✗ Falls into the 'category confusion' trap. The deceased is the unpaid caregiving spouse Sam rather than the income–earning spouse Elena; the primary shortfall is loss of caregiver rather than loss of income.

2 answer b

a. ✗ Falls into the 'mechanics confusion' trap. A healthy lifestyle cannot eliminate death itself and therefore is not risk avoidance; absorbing minor expenses through personal savings is risk retention rather than reduction; purchasing insurance is risk transfer rather than retention.

b. ✓ Correct. The risk of death cannot be avoided because living inherently exposes one to it (risk avoidance is inapplicable); however, quitting smoking and workplace safety measures postpone death and lower the probability of premature death, representing risk reduction. Using personal liquid assets to absorb affordable minor losses represents risk retention. Transferring the substantial $600,000 shortfall that exceeds the family's financial capacity to an insurance company represents risk transfer.

c. ✗ Falls into the 'mechanics confusion' trap. Risk avoidance means completely refraining from the activity that generates the risk, which is entirely inapplicable to the risk of death; mitigating or transferring financial consequences cannot be termed risk avoidance.

d. ✗ Falls into the 'mechanics confusion (ruling out retention or reduction simply because death is involved)' trap. The exam standard explicitly allows a combination of strategies: combining risk reduction measures, retaining affordable portions, and transferring shortfalls exceeding personal capacity through insurance.

2′ answer d

a. ✗ Falls into the 'mechanics confusion' trap. The amount of wealth cannot alter the certainty of death; risk avoidance does not apply to the risk of death.

b. ✗ Falls into the 'concept confusion' trap. Risk transfer distributes losses among policyholders through premiums (risk sharing); using one's own savings does not transfer risk to a third party.

c. ✗ Falls into the 'mechanics confusion' trap. Risk reduction consists of preventive measures that decrease the probability or severity of an occurrence; setting aside cash does not reduce mortality.

d. ✓ Correct. Although most families cannot afford to retain catastrophic losses from death, the exam standard notes that risk retention should not be ruled out solely because the risk of death is involved; when a client has ample liquid assets and the potential loss is fully within their financial capacity, retention is a viable option.

3 answer c

a. ✗ Falls into the 'concept confusion (equating no estate tax with no taxes at death)' trap. While the 1972 tax reform abolished the federal estate tax, it simultaneously introduced the deemed disposition mechanism on capital property at death for income tax purposes.

b. ✗ Falls into the 'concept confusion' trap. Neither the Canadian federal government nor any province (including BC) levies an estate tax or inheritance tax; tax liabilities at death stem from deemed disposition and the inclusion of registered accounts under the Income Tax Act.

c. ✓ Correct. Although Canada has no estate tax, death triggers a deemed disposition: the cottage is deemed sold at its fair market value of $920,000 immediately prior to death, with the $800,000 gain taxed at the applicable inclusion rate as a taxable capital gain; furthermore, because the beneficiary is an adult daughter who does not qualify for a rollover (neither a spouse nor a qualifying dependent), the full RRIF balance is included in Raymond's final taxable income at his marginal tax rate.

d. ✗ Falls into the 'concept confusion' trap. Automatic rollover of capital property applies only to a qualifying spouse, spousal trust, and certain farm or fishing property transfers; an ordinary vacation cottage and a RRIF left to an adult child cannot be rolled over.

3′ answer a

a. ✓ Correct. Death triggers a deemed disposition, deeming the non–registered portfolio sold at its fair market value of $750,000. Because the heir is an adult nephew (ineligible for a spousal rollover), the $550,000 capital gain is included at the applicable inclusion rate on Evelyn's final tax return and taxed at her marginal tax rate.

b. ✗ Falls into the 'concept confusion (equating no estate tax with no taxes at death)' trap. The absence of an estate tax does not mean there is no capital gains tax triggered by deemed disposition.

c. ✗ Falls into the 'concept confusion' trap. The Lifetime Capital Gains Exemption (LCGE) applies only to qualified small business corporation shares and qualified farm or fishing property; it does not apply to a portfolio of publicly traded shares.

d. ✗ Falls into the 'concept confusion' trap. The spousal rollover is restricted to a qualifying spouse or spousal trust; an adult nephew does not qualify for a rollover.

4 answer b

a. ✗ Falls into the 'concept confusion' trap. Qualified small business corporation shares can utilize the Lifetime Capital Gains Exemption (LCGE) upon deemed disposition at death if conditions are met, and gains exceeding the exemption are taxed as capital gains rather than employment income.

b. ✓ Correct. This question tests the exam standard benchmark (note: the 2022 exam standard LCGE is $913,630, while the 2026 current ceiling has increased to $1,275,000). Whether using the exam standard of $913,630 or the current $1,275,000, the Lifetime Capital Gains Exemption (LCGE) can only partially offset capital gains; with $2,400,000 in share appreciation, the portion exceeding the exemption remains taxable upon deemed disposition at death and must be paid before estate distribution.

c. ✗ Falls into the 'sample exam wording versus practical tax law confusion' trap. Bequeathing appreciated corporate shares to an adult child does not qualify for a spousal rollover, triggering a deemed disposition tax liability immediately upon death.

d. ✗ Falls into the 'concept confusion' trap. The lump-sum CPP death benefit is a government benefit paid to the estate or survivors; it is not deducted from corporate retained earnings.

4′ answer a

a. ✓ Correct. This question tests the scope of the Lifetime Capital Gains Exemption (LCGE) (note: 2022 exam standard is $913,630; 2026 current ceiling is $1,275,000). The lecture notes clearly state that the LCGE covers only qualified small business corporation shares and qualified farm or fishing property (including eligible family farm or fishing partnership interests); an ordinary commercial partnership cannot be presumed eligible, so deemed disposition upon death cannot be sheltered by the LCGE.

b. ✗ Falls into the 'concept fabrication' trap. The Lifetime Capital Gains Exemption (LCGE) has no age ceiling restricting eligibility upon death at age 65.

c. ✗ Falls into the 'concept confusion' trap. Canada abolished the federal estate tax in 1972; partnership interests are likewise subject to the deemed disposition rules for capital property.

d. ✗ Falls into the 'concept confusion' trap. The CPP survivor's pension is a monthly benefit paid to an eligible spouse or common-law partner; a brother and business partner is not eligible to receive it.

5 answer d

a. ✗ Falls into the 'dual-benchmark blind application' trap. The table figures represent maximum amounts (ceilings); because her husband contributed at low earnings for only eight years, the maximum cannot simply be plugged into needs analysis without assessing actual entitlement.

b. ✗ Falls into the 'age bracket mismatch' trap. Hannah is only 58 years old (under age 65) and therefore does not qualify for the age 65 and over ceiling, nor can maximum figures be applied automatically.

c. ✗ Falls into the 'concept confusion' trap. The CPP applies to all provinces outside Quebec, including BC, and the first tier of needs analysis is specifically calculating expected government benefit payouts.

d. ✓ Correct. This question tests the exam standard benchmark and assessment principles (note: the maximum monthly CPP survivor's pension for survivors under age 65 is $674.79 under the 2022 exam standard and $803.54 under the 2026 current table; the lump-sum death benefit is $2,500 under the exam standard, and up to $5,000 with qualifying conditions from 2025 onward). While candidates must recognize table maximums for the exam, needs analysis must assess actual contribution eligibility and estimated entitlement rather than universally plugging in maximum figures.

5′ answer a

a. ✓ Correct. This question compares the exam standard against current rules (note: the maximum monthly CPP survivor's pension for survivors age 65 and over is $752.15 under the exam standard and $904.59 under the 2026 current ceiling; the basic lump-sum death benefit is $2,500 under the exam standard, and up to $5,000 under qualifying conditions from 2025 onward). When a survivor age 65 or over concurrently receives their own CPP retirement pension, a combined ceiling applies; furthermore, the additional $2,500 requires verifying conditions such as not receiving retirement or disability benefits (Walter's wife is 67, so one cannot blindly assume receiving the full $5,000).

b. ✗ Falls into the 'concept fabrication' trap. Survivors age 65 and over have a dedicated monthly survivor pension bracket; eligibility is not eliminated.

c. ✗ Falls into the 'dual-benchmark blind application' trap. Overlooks the combined ceiling mechanism when a survivor age 65 or over concurrently receives their own retirement pension and survivor pension, as well as the eligibility restrictions on the additional $2,500 death benefit.

d. ✗ Falls into the 'bracket mismatch' trap. The age 65 threshold for the survivor's pension is determined by the surviving spouse Walter's own age (67), rather than applying the under age 65 bracket.

6 answer a

a. ✓ Correct. Based on the life cycle life insurance needs curve for a BC family: during family formation and home purchase (Client X), the three most pressing impacts—loss of income, loss of caregiver, and mortgage debt repayment—combine to reach their lifetime peak; upon entering retirement (Client Y), loss of income diminishes, but charitable bequests requiring estate creation and un-transferred corporate shares triggering business impacts and deemed disposition taxes become the primary needs.

b. ✗ Falls into the 'stage reversal' trap. Completely reverses the core risks of a young family raising children with a mortgage and a retired business owner.

c. ✗ Falls into the 'category omission (evaluating the six impacts as a single all-or-nothing block)' trap. Case C highlights that one cannot assume the remaining categories of impact (especially estate creation and deemed disposition taxes on shares) automatically disappear simply because lost earned income and mortgage debts have ended.

d. ✗ Falls into the 'concept confusion' trap. Exposure to financial impacts of death is not a static amount; it evolves dynamically across life stages such as being single, starting a family, peak career, and retirement.

6′ answer b

a. ✗ Falls into the 'character and stage misattribution' trap. Childcare and mortgage obligations belong to Kevin who is starting a family, whereas group insurance conversion upon retirement belongs to Patricia.

b. ✓ Correct. According to the life cycle needs curve, Patricia in retirement faces the termination of group life insurance upon retiring and must decide within a limited window whether to exercise her conversion privilege (covered in ch06/ch12); meanwhile, Kevin in the family formation and home purchase stage experiences a sharp surge in loss of income, loss of caregiver, and mortgage debt repayment (covered in ch02/ch10).

c. ✗ Falls into the 'mortality curve misunderstanding' trap. Age-specific probability of death is low in youth but never zero, and while it accelerates by age 64, it is far from 100 percent.

d. ✗ Falls into the 'reversal of nature and process' trap. Life insurance is not an investment tool, and any coverage recommendation must be preceded by a needs analysis.

7 answer c

a. ✗ Falls into the 'mortality curve direction reversal' trap. From young adulthood to middle age and into older age, the age-specific probability of death increases non-linearly with age rather than decreasing.

b. ✗ Falls into the 'mechanics confusion' trap. As long as someone is alive, they are exposed to the risk of death; risk avoidance does not apply to the risk of death at any age.

c. ✓ Correct. Although the age-specific probability of death is very low during youth, should it occur, the severity of the loss of income and loss of caregiver for a young family is exceptionally high, exceeding personal retention capacity. Moreover, because the mortality curve accelerates non-linearly with age, transferring the risk when young—when the probability of death is lowest and premiums are cheapest—locks in coverage cost-effectively.

d. ✗ Falls into the 'concept confusion' trap. CISRO competency component c1 (assessing the client's needs and situation, carrying a 35 percent weight) applies to evaluating client needs across all age brackets, with no special relevance to reaching age 65.

7′ answer a

a. ✓ Correct. CISRO competency component c1 holds a 35 percent weighting, in which Chapter 1 establishes the qualitative framework of the risk of death, six financial impacts, and four risk management strategies to determine which risks require risk transfer, while the quantitative heavy lifting of calculating face amounts using the income replacement approach or capital needs approach is centered in Chapter 10's needs analysis.

b. ✗ Falls into the 'weight allocation misunderstanding' trap. 35 percent is the weight for the entire c1 component (Chapter 1 plus Chapter 10), and exam testing focuses heavily on the needs analysis calculations of Chapter 10, without requiring rote memorization of the entire mortality table.

c. ✗ Falls into the 'reversal of nature and process' trap. The practice workflow requires conducting a fact-finding interview and needs analysis (Chapter 10) first to quantify the shortfall, before selecting products and writing recommendations (Chapter 11); an agent must never pitch products first.

d. ✗ Falls into the 'concept confusion' trap. Group insurance conversion is covered in Chapter 6 and Chapter 12, and Canadian provinces do not levy an inheritance tax.

Chapter 2 answers and reasons

8 answer a

a. ✓ Correct. Exercising convertibility is not canceling and reissuing, but the continuation of existing contractual rights: not only is proof of insurability waived, but the two-year statutory clocks for both the incontestability period and the suicide exclusion clause continue running from the original term policy issue date, and after five years they have long since expired.

b. ✗ Falls into the 'assuming conversion resets the two-year clocks' trap. The commencement of both the incontestability period and the suicide exclusion clause continues from the original term policy issue date; as long as the face amount is a standard conversion, the suicide exclusion clause does not restart for two years on the conversion date.

c. ✗ Falls into the 'assuming conversion resets the two-year clocks' trap, treating convertibility as surrendering and reapplying for new coverage. Restarting the two-year clocks would strip convertible term insurance of its core contractual benefit.

d. ✗ Violates the principle that convertibility requires no proof of insurability. The core essence of convertibility is continuing the two-year clocks running from the original issue date without submitting any new proof of insurability.

8′ answer c

a. ✗ Falls into the 'assuming conversion resets the two-year clocks' trap. Even though the original term policy is still within the two-year window, conversion does not erase the one year already elapsed and reset the clock to zero.

b. ✗ Misunderstands the clock continuation rule. Conversion calculates the two-year period from the original term policy issue date; since the original policy has been in force for one year, the remaining one year carries over into the permanent contract rather than being immediately waived.

c. ✓ Correct. Upon exercising convertibility, both the incontestability period and the suicide exclusion clause continue running from the original term policy issue date; since one year has passed on the term policy, the remaining one year carries over into the permanent policy to complete the two-year requirement.

d. ✗ Falls into the 'assuming conversion resets the two-year clocks' trap. Both the incontestability period and the suicide exclusion clause run from the original contract issue date, and the incontestability period does not restart separately.

9 answer b

a. ✗ Applies the mechanics of attained-age conversion to original-age conversion. Pricing premiums at the age at conversion without requiring a lump-sum retroactive payment is the feature of Policy X (attained-age conversion).

b. ✓ Correct. Original-age conversion (retroactive conversion) calculates permanent premiums based on the age when the term policy was originally issued, but the policyholder must pay a lump-sum adjustment covering the past five years of premium differences (or accumulated cash values) plus possible interest; under exam conventions, attained-age conversion is the standard market design, and in practice one must evaluate the initial term premium, the lump-sum back payment, and ongoing future premiums together.

c. ✗ Falls into the 'blindly assuming original-age conversion is always more cost-effective' trap. Original-age convertible term policies charge higher term premiums from the outset, and when combined with the substantial lump-sum retroactive payment at conversion, the total outlay is not necessarily lower.

d. ✗ Confuses conversion pricing mechanics with underwriting requirements. Whether under attained-age conversion or original-age conversion, exercising convertibility within the contractual conversion window requires no new proof of insurability.

9′ answer d

a. ✗ Violates the principle that convertibility requires no medical underwriting. Attained-age conversion, like original-age conversion, requires no proof of insurability.

b. ✗ Fabricates a non-existent rule. Original-age conversion merely calculates ongoing permanent premiums based on the lower age at initial issue, but does not waive ongoing future premiums.

c. ✗ Violates the fundamental nature of term life insurance. Term life insurance accumulates no cash value, and attained-age conversion itself requires no retroactive back payment.

d. ✓ Correct. Original-age conversion obligates the insurer to provide permanent coverage at the lower rate of a younger issue age, so the initial term premium is higher than that of an attained-age conversion policy, and a lump-sum payment of premium or cash value differences plus possible interest is required at conversion.

10 answer c

a. ✗ Falls into the 'confusing renewability with convertibility' trap. Convertibility and renewability have separate age cutoffs; Arthur is 69, which exceeds the contractual age 65 conversion limit, so he can no longer convert to permanent coverage without medical evidence.

b. ✗ Falls into the 'confusing renewability with convertibility' trap. Renewability and convertibility are independent contractual rights; passing the age 65 conversion window does not affect his ability to exercise renewability up to age 85.

c. ✓ Correct. Under exam conventions, conversion and renewal age limits must be answered strictly according to figures specified in the contract (while verifying actual policy wording in practice); although Arthur has passed the age 65 convertibility cutoff, he remains within the age 85 renewability cutoff and can renew term coverage without proof of insurability at his attained age of 69.

d. ✗ Misunderstands renewal pricing rules. Exercising renewability requires no proof of insurability, but the premium must be recalculated using the age at renewal (age 69) rather than retaining the original rate from ten years ago.

10′ answer a

a. ✓ Correct. A term policy may possess convertibility without renewability; Beatrice is 60 and still within the contractual age 65 conversion window, so she can convert to permanent insurance before term expiry without proof of insurability.

b. ✗ Falls into the 'confusing renewability with convertibility' trap. Renewability and convertibility are mutually independent; being non–renewable does not mean a policy is non–convertible.

c. ✗ Falls into the 'confusing renewability with convertibility' trap. Age 65 is her convertibility cutoff, but the contract is explicitly non–renewable and cannot be renewed as term coverage upon expiry.

d. ✗ Violates the principle that convertibility requires no medical underwriting. Exercising convertibility within the conversion window is completely unaffected by current health changes, and the insurer cannot require any new proof of insurability.

11 answer d

a. ✗ Mistakenly assumes that exercising convertibility requires verifying test results like a new policy application. The underwriting waiver under convertibility applies regardless of current medical abnormalities or pending investigations, so there is no need to wait for test results.

b. ✗ Violates the principle that convertibility requires no proof of insurability. Exercising convertibility is the continuation of existing contractual rights; the insurer cannot demand new proof of insurability nor add medical exclusions due to health changes at conversion.

c. ✗ Confuses the expiry renewal date with the conversion window. Convertibility can be exercised at any time within the policy term prior to the maximum conversion age (age 65), without requiring benign medical findings as a prerequisite.

d. ✓ Correct. The core value of convertibility is the complete waiver of proof of insurability; as long as Nadia exercises conversion within the age 65 conversion window, the insurer is contractually obligated to issue permanent coverage regardless of abnormal test results or pending investigations.

11′ answer b

a. ✗ Confuses the duty of disclosing material facts during a new application with exercising convertibility. Conversion is not applying for new insurance; no new health declaration or proof of insurability is required, and the original policy has been in force for five years, well past the two-year incontestability period.

b. ✓ Correct. Convertibility is an established right locked into the contract at issue; as long as it is exercised within the conversion window, the insurer cannot demand any new proof of insurability, regardless of pending symptoms or specialist testing results.

c. ✗ Violates convertibility provisions. The insurer has no right to postpone or suspend a valid conversion application within the eligible window simply because the life insured is undergoing medical testing.

d. ✗ Falls into the 'assuming conversion resets the two-year clocks' trap. The permanent policy issued upon conversion continues from the original issue date five years ago, so the two-year incontestability period does not restart.

12 answer a

a. ✓ Correct. Although the death benefit of an individual decreasing term policy decreases over time, premiums typically remain level throughout the term (as the average risk across the entire term is factored into the level rate), and the policyholder can freely name beneficiaries while enjoying full portability; exam conventions classify lender mortgage insurance as non-portable group decreasing term where benefits are paid directly to the lender.

b. ✗ Falls into the 'assuming decreasing term premiums decrease alongside coverage' trap. Decreasing term insurance reduces the death benefit over time, while premiums typically remain level throughout the contract rather than decreasing alongside coverage.

c. ✗ Confuses lender mortgage insurance with individual level term insurance. Lender mortgage insurance typically covers only the declining mortgage balance and designates the lender as the beneficiary, paying no excess balance to the spouse.

d. ✗ Confuses lender mortgage insurance with individual term life insurance. Lender mortgage insurance is tied to the specific loan, names the lender as beneficiary, and cannot be ported or changed to designate children as beneficiaries.

12′ answer b

a. ✗ Violates the fundamental rule that term life insurance has no cash value. Decreasing term insurance never accumulates any cash value.

b. ✓ Correct. In standard decreasing term insurance, only the death benefit decreases over time, while the insurer factors the average risk exposure over the full term into a level premium, keeping premiums constant throughout the contract.

c. ✗ Confuses decreasing term with increasing term insurance or riders. Level premiums represent the standard pricing structure inherent to decreasing term insurance itself.

d. ✗ Falls into the 'assuming decreasing term premiums decrease alongside coverage' trap. Premiums on decreasing term insurance typically remain fixed across the entire contract term, and no rule exists where premiums drop after 10 years.

13 answer c

a. ✗ Misunderstands the effect of marital status on policy validity. A joint first–to–die policy covers two lives insured, and a divorce does not automatically terminate the policy.

b. ✗ Falls into the 'confusing life insured status with policyholder control' trap. Joint first–to–die simply means both individuals are lives insured and the benefit pays on the first death; it does not grant both lives insured equal policyholder change rights.

c. ✓ Correct. Policy control belongs strictly to the policyholder (subject to irrevocable beneficiary, collateral assignment, or court order restrictions) and operates independently of changes in marital status; the husband is merely a life insured rather than the policyholder and holds no right to change the beneficiary.

d. ✗ Misunderstands joint first–to–die payout structure and control. Joint first–to–die covers a single face amount and pays only once upon the first death (which is why its premium is lower than two individual policies); neither party holds independent control over half the coverage.

13′ answer a

a. ✓ Correct. Joint first–to–die covers two lives under a single benefit amount and pays out once upon the first death; the insurer is exposed to the risk of paying only one claim, which represents actual risk savings inherent to joint coverage rather than a simple marketing discount.

b. ✗ Confuses joint first–to–die with joint last–to–die insurance. Payouts occurring only upon the death of the second insured characterize joint last–to–die policies, commonly used to cover deferred death taxes.

c. ✗ Fabricates a non–existent restriction. The fundamental reason for lower premiums on joint first–to–die policies is the single death benefit payout, not any blanket prohibition on renewability or convertibility.

d. ✗ Distorts the definition of first–to–die. Joint first–to–die triggers a claim upon the first death of either insured during the term; it does not require both insureds to die in the same event.

14 answer b

a. ✗ Completely reverses the appropriate use cases for level and decreasing term insurance. A declining mortgage balance suits decreasing term to save premium costs, whereas child dependency income replacement and estate planning represent non–declining needs best covered by level term.

b. ✓ Correct. Level term maintains a constant death benefit, matching constant child dependency needs; increasing term addresses shortfalls expanding with inflation or income growth, though under exam conventions and Canadian market practice, standalone increasing term policies are rare and typically implemented via riders or layered level policies.

c. ✗ Contradicts Canadian market realities. Level term is the most common form, whereas standalone increasing term contracts are rare in Canada, and increasing coverage is never accompanied by decreasing premiums.

d. ✗ Violates the fundamental purpose of term life insurance. Term insurance is designed specifically to cover known or estimable time windows (with exam bands including 1, 5, 10, or 20 years and modern practice offering custom annual terms), without mandating permanent whole life for temporary needs.

14′ answer d

a. ✗ Puts the cart before the horse by treating rounding up as a needs analysis standard, potentially causing the client to pay unnecessary premiums for unneeded years.

b. ✗ Reverses the logical workflow sequence. Without first measuring the time window of risk exposure, one cannot determine appropriate term lengths or future conversion needs.

c. ✗ Mistakes industry conventions for statutory requirements. Term length bands are not legally mandated, but are tools designed to match the duration of a client's actual risk.

d. ✓ Correct. Term life insurance covers a truncated window of mortality risk; the agent's first step in needs analysis is to measure the known or estimable time window of risk (such as remaining mortgage amortization or years until children become independent), and only then match standard bands or custom terms (answering exam questions using given bands, while measuring exact liability duration in practice).

Chapter 3 answers and reasons

15 answer a

a. ✓ Correct. Holders of participating (par) policies enjoy a contractual right to participate in surplus distributions, but whether a dividend is declared and how much is paid each year are determined at the sole discretion of the insurer's board of directors, representing a non-guaranteed benefit.

b. ✗ Falls into the 'confusing contractual participation rights with dividend amounts' trap. This mistakenly equates the contractual right of participation with a mandatory annual dividend or a guaranteed minimum dividend scale interest rate; in reality, dividends can drop to zero under extreme conditions.

c. ✗ Falls into the 'misconception of loss sharing' trap. Neither participating nor non-participating policyholders bear the insurer's corporate losses, and guaranteed death benefits and guaranteed cash surrender value tables written into the contract never diminish due to poor company performance.

d. ✗ Falls into the 'confusing policy dividends with shareholder dividends' trap. Policy dividends stem from the actuarial distribution of surplus in the participating account and are completely different in legal character and tax treatment from corporate shareholder dividends.

15′ answer c

a. ✗ Falls into the 'treating premium offset illustrations as contractual promises' trap. The non-guaranteed column in a policy illustration is merely a projection based on the current dividend scale interest rate assumption, not a contractually guaranteed promise.

b. ✗ Falls into the 'conflating guaranteed and non-guaranteed values' trap. The guaranteed cash surrender value table is fixed in the contract at issue, and the insurer has no obligation to raise guaranteed cash values to offset a reduction in non-guaranteed dividends.

c. ✓ Correct. Dividend amounts under a participating policy are subject to the board's annual discretion and are not guaranteed; failing to match non-guaranteed illustrations does not constitute a breach of contract, while the contractually guaranteed death benefit and cash surrender values remain entirely intact.

d. ✗ Falls into the 'fabricating premium refund rights' trap. Adjusting the dividend scale to reflect changes in mortality, expense, and investment experience is a normal mechanism of participating insurance; the policyholder can only surrender for the cash surrender value (CSV) and has no legal right to demand a full refund of past premiums.

16 answer b

a. ✗ Falls into the 'confusing dividend option mechanics' trap. Premium reduction merely applies declared dividends to offset upcoming premium dues and does not increase the policy's death benefit whatsoever.

b. ✓ Correct. Purchasing paid-up additions (PUA) applies declared dividends as single premiums to purchase small parcels of paid-up permanent coverage, permanently increasing both total death benefit and future cash values without medical underwriting (no evidence of insurability required); according to the exam benchmark, over 90% of participating policies choose this option (note: this percentage is an exam narrative statement without public empirical validation in current practice).

c. ✗ Falls into the dual trap of 'treating paid-up additions as an underwritten rider' and 'rate misapplication'. Leaving dividends to accumulate at interest merely deposits them in an insurer account earning a separate deposit interest rate, available for withdrawal at any time; it neither earns the dividend scale rate nor converts into permanent coverage.

d. ✗ Falls into the 'treating paid-up additions as an underwritten rider' trap. Purchasing a separate rider or new policy requires additional out-of-pocket funds and usually requires medical underwriting, whereas PUA automatically purchases paid-up permanent insurance directly with dividends without underwriting.

16′ answer a

a. ✓ Correct. Purchasing paid–up additions (PUA) uses declared annual dividends as single premiums to purchase small paid–up permanent policies without underwriting; the exam benchmark explicitly asserts that over 90% of participating policies use PUA (note: candidates answer using this exam benchmark statement, though in current point–of–sale practice this figure lacks public industry statistical sourcing and must not be cited to clients as current data).

b. ✗ Falls into the 'mechanism confusion' trap. Accumulate at interest leaves dividends on deposit with the insurer to earn deposit interest and does not purchase paid–up permanent coverage.

c. ✗ Falls into the 'mechanism confusion' trap. Premium reduction applies dividends against required premiums, failing to increase permanent coverage or accumulate corresponding PUA cash values.

d. ✗ Falls into the 'treating non–forfeiture options as dividend choices' trap. Extended term insurance is a non–forfeiture benefit option invoked upon stopping premium payments, not an annual dividend distribution choice.

17 answer c

a. ✗ Falls into the 'assuming loans are not deducted from death benefits' trap. A policy loan is an advance provided by the insurer secured by the policy's value; if unpaid, the loan principal and accrued interest are deducted from both surrender values and death benefit proceeds.

b. ✗ Falls into the 'stacking death benefits on top of cash value' trap. Traditional whole life insurance pays the face amount upon death (minus outstanding loan balances); cash surrender value represents a living surrender right and is not paid out in addition to the face amount upon death.

c. ✓ Correct. Outstanding policy loan principal and accrued interest are deducted from the death benefit upon the death of the life insured: $300,000 – ($50,000 + $6,500) = $243,500 (note: the exam benchmark often uses 90% of CSV, or $72,000, as an illustrative borrowing limit, whereas in practice specific limits and loan rates are governed by contract provisions).

d. ✗ Falls into the 'omitting loan interest' trap. Policy reserves are not interest–free personal bank deposits held for the client; policy loans accrue interest at current rates, and both unpaid principal and accrued interest ($56,500 total) must be deducted from the death benefit.

17′ answer b

a. ✗ Falls into the 'assuming full borrowing without debt deduction' trap. The standard exam benchmark commonly limits policy loans to 90% of CSV (meaning $54,000, not 100% or $60,000), and upon surrender, the outstanding loan balance of $42,000 must be deducted.

b. ✓ Correct. Based on the common exam benchmark limit of 90% of CSV, the maximum loan today is $60,000 x 90% = $54,000; upon surrendering one year later, the outstanding loan balance ($42,000) is deducted directly from the gross CSV ($63,000), yielding a net payout of $63,000 – $42,000 = $21,000 (note: while the exam cites 90% as the benchmark limit, actual limits in practice must be verified in the specific contract).

c. ✗ Falls into the 'calculating surrender proceeds from death benefit' trap. Subtracting the loan from the face amount ($250,000 – $42,000 = $208,000) is the calculation used upon death; lifetime surrender proceeds are calculated solely by deducting debt from the cash surrender value ($63,000).

d. ✗ Falls into the 'basing loan limits on face amount' trap. Policy loan limits are based on 90% of cash surrender value ($54,000), never 90% of the death benefit face amount ($225,000).

18 answer d

a. ✗ Falls into the 'confusing APL with paid–up options' trap. Automatic premium loan (APL) is a temporary measure that advances unpaid premiums against CSV to prevent accidental lapse; it accrues loan interest and does not achieve the goal of permanently stopping premium payments.

b. ✗ Falls into the 'mixing up reduced paid–up insurance and extended term insurance' trap. Although reduced paid–up insurance permanently eliminates premiums for life, the death benefit is substantially reduced, failing Arthur's objective of keeping the full $350,000 face amount.

c. ✗ Falls into the 'surrender wipeout' trap. Taking the cash surrender value directly terminates the policy contract entirely, reducing death benefit coverage to zero immediately.

d. ✓ Correct. Extended term insurance uses the existing cash surrender value (CSV) as a single premium to purchase term life insurance for the original face amount ($350,000) for a limited duration determined by the CSV amount and the insured's attained age, requiring no further premiums and accruing no loan interest.

18′ answer a

a. ✓ Correct. Reduced paid–up insurance applies the accumulated cash surrender value (CSV) as a single premium to purchase a paid–up permanent policy with a reduced face amount that covers the insured for life, requiring no further premium payments whatsoever.

b. ✗ Falls into the 'mixing up reduced paid–up insurance and extended term insurance' trap. Extended term insurance preserves the full original face amount but only for a limited term, expiring with zero coverage thereafter, which fails her goal of guaranteed lifetime coverage for final expenses.

c. ✗ Falls into the 'misunderstanding procedural sequence' trap. Automatic premium loan (APL) continually drains CSV while accruing loan interest; once total debt reaches the CSV limit (commonly 90% to 100%), the policy will lapse after the requisite notice period, failing to provide permanent premium–free coverage.

d. ✗ Falls into the 'fabricating conversion rules' trap. Term–100 is a standalone level–premium product requiring premium payments up to age 100, not a non–forfeiture paid–up option under a whole life policy.

19 answer b

a. ✗ Falls into the 'treating premium offset illustrations as contractual promises' trap. Premium offset (vanishing premium) is never a contractually guaranteed fixed period, but rather a non–guaranteed projection based on dividend scale assumptions at a specific point in time.

b. ✓ Correct. Premium offset relies on non–guaranteed dividend assumptions; when dividend scales decline, accumulated dividends and PUA cash values are insufficient to offset premiums on schedule, causing the required offset point to be pushed back automatically; this is precisely why regulators require illustrations and annual statements to display guaranteed and non–guaranteed columns side by side.

c. ✗ Falls into the 'confusing premium offset with limited–pay policies' trap. Only a contractually defined 15–pay policy automatically becomes fully paid–up at year 15; running a premium offset illustration on a life–pay policy does not convert the contract into a paid–up policy.

d. ✗ Falls into the 'assuming historical dividend scales are locked in' trap. The dividend scale is redetermined annually by the board of directors based on actual mortality, expense, and investment experience, and policyholders have no legal right to lock in the dividend scale from the issue year.

19′ answer a

a. ✓ Correct. Following the vanishing premium controversies of the 1970s and 1980s, regulatory and industry standards mandate that policy illustrations present guaranteed and non-guaranteed columns side by side, with clients signing an acknowledgement confirming that non-guaranteed figures are not promises.

b. ✗ Falls into the 'one-sided reporting' trap. An advisor must never display only optimistic non-guaranteed projections, but must present guaranteed and non-guaranteed columns side by side.

c. ✗ Falls into the 'treating premium offset illustrations as contractual promises' trap. Premium offset depends on future non-guaranteed dividend performance, and presenting it as a contractually guaranteed fixed premium-stop date is strictly prohibited.

d. ✗ Falls into the 'metric misapplication' trap. The dividend scale interest rate is merely an internal actuarial parameter of each insurer, not a guaranteed return, and cannot be used directly for cross-company comparisons to determine which policy yields higher cash value.

20 answer c

a. ✗ Falls into the 'assuming term insurance provides lifetime coverage' trap. Renewal premiums for term insurance spike steeply and coverage terminates at an advanced age (such as age 65 to 80), making it incapable of covering inevitable estate taxes upon death or fulfilling permanent charitable bequests.

b. ✗ Falls into the 'assuming limited-pay par insurance has low premiums' trap. A limited-payment (20-pay) participating policy accumulating cash values carries the highest periodic premium among comparable products, contradicting Gordon's goal of sacrificing living cash values in exchange for the lowest level lifetime premium.

c. ✓ Correct. Term-100 uses level cost of insurance (LCOI) pricing with guaranteed level premiums capped at age 100 for lifetime coverage; because it typically accumulates no cash surrender value (CSV) or non-forfeiture benefits, its premiums are lower than whole life, making it ideal for permanent obligations like capital gains tax or fixed-amount charitable bequests that require no living cash access.

d. ✗ Falls into the 'assuming Term-100 only pays at maturity' trap. Term-100 is priced based on whichever comes first between death or age 100; as long as premiums are paid, it covers the insured for life and pays the face amount upon death at any age.

20′ answer b

a. ✗ Falls into the 'treating Term-100 as yearly renewable term' trap. Term-100 uses level cost of insurance pricing with premiums fixed from issue until fully paid up at age 100, never increasing annually.

b. ✓ Correct. Term-100 is a permanent policy intentionally designed without savings features; early premium overpayments exist solely to support level lifetime rates and do not provide the policyholder with cash surrender values (CSV), policy loans, or non-forfeiture options like reduced paid-up insurance.

c. ✗ Falls into the 'treating Term-100 as renewable term insurance' trap. Term-100 is classified as permanent insurance; it does not expire and requires no renewal underwriting.

d. ✗ Falls into the 'treating typical case scenarios as absolute rules' trap. Charitable giving and capital gains tax liabilities are merely typical uses for Term-100; designating beneficiaries is not legally restricted to charitable institutions.

21 answer c

a. ✗ Falls into the 'applying whole life lapse buffers to Term–100' trap. Although Term–100 maintains internal actuarial reserves to support level premiums, it makes no cash surrender value (CSV) accessible to the policyholder, preventing an automatic premium loan (APL) from triggering.

b. ✗ Falls into the 'applying whole life lapse buffers to Term–100' trap. Without cash surrender value (CSV), it is impossible to purchase reduced paid–up insurance or extended term insurance.

c. ✓ Correct. According to the exam benchmark, a standard Term–100 policy without cash surrender value (CSV) cannot rely on APL advances or convert to paid–up coverage, lapsing outright to zero once the grace period ends, though some contracts permit applying for reinstatement within roughly two years (note: while the exam benchmark broadly mentions reactivation within approximately two years, under current BC Insurance Act s. 57, standard individual life policies have a further 30–day window to reinstate by paying the overdue premium while the insured is alive, plus a two–year conditional statutory reinstatement right following lapse).

d. ✗ Falls into the 'fabricating premium refund rights' trap. Term–100 has no non–forfeiture benefits or cash surrender value, and upon policy lapse the insurer does not refund any previously paid premiums.

21′ answer a

a. ✓ Correct. Non–forfeiture benefits and automatic premium loans (APL) in traditional whole life rely entirely on accessible cash surrender value (CSV) as their funding source; because Term–100 typically accumulates no CSV, it lapses outright once the grace period expires (note: while the exam benchmark stresses that Term–100 terminates directly without CSV buffers, BC practice still requires reviewing statutory reinstatement rights under Insurance Act s. 57).

b. ✗ Falls into the 'confusing product categories' trap. Regulators and the industry classify Term–100 as permanent insurance because it never expires and requires no renewal underwriting; it lacks cash surrender value, not permanent insurance status.

c. ✗ Falls into the 'assuming grace periods are absent' trap. Standard individual life insurance policies (whether whole life or Term–100) provide a 30–day grace period (not counting the due date) for unpaid renewal premiums (28 days for industrial life).

d. ✗ Falls into the 'assuming statutory rights are waived' trap. Purchasing Term–100 forfeits cash surrender values and non–forfeiture savings flexibility, but does not waive statutory reinstatement rights.

Chapter 4 answers and reasons

22 answer a

a. ✓ Correct. The bottom line for keeping a universal life insurance policy in force is that the accumulating fund value must always be sufficient to cover the monthly cost of insurance (COI) and administration charges. Paying only the minimum premium long term (minimally funded), taking large or partial withdrawals of account value, and experiencing negative returns in index accounts simultaneously cause the account to stagnate while the net amount at risk (NAAR) remains high—preventing deduction amounts from dropping, rapidly exhausting the account value, and triggering lapse risk.

b. ✗ Falls into the 'misjudging scope' trap. The exemption test restricts depositing excess funds into a policy rather than withdrawing funds; a partial withdrawal threatens policy survival because it drains the account value and weakens the virtuous circle, not because it violates the exemption test.

c. ✗ Makes two errors simultaneously: first, only daily interest accounts (DIA) and guaranteed investment accounts (GIA) typically carry a 0% floor, whereas index-linked or fund-linked accounts can suffer investment losses; second, universal life insurance has no 6% modal factor.

d. ✗ Conflates design targets with contractual guarantees. Exam benchmarks explain that while minimum funding is often designed to keep coverage in force to a specified age (such as age 100), this is not a contractual guarantee of lifetime coverage; if actual returns turn negative or withdrawals occur, the policy can still lapse due to an insufficient balance.

22′ answer c

a. ✗ Conflates pausing premiums with a policy surrender. Surrender charges are levied only when the policy is formally surrendered in its first 5 to 10 years; pausing premium deposits (as long as the account value covers deductions) does not trigger a surrender charge.

b. ✗ Fabricates an ungrounded rule. Pausing premiums does not automatically change the death benefit option; the policy simply relies on the existing accumulating fund balance to continue paying monthly charges.

c. ✓ Correct. When fund-linked accounts underperform or suffer losses while the client pauses premium deposits, a dual headwind is triggered: the accumulating fund itself shrinks, and because the account value fails to reduce the net amount at risk (NAAR), monthly cost of insurance (COI) deductions remain high, rapidly draining the account value.

d. ✗ Mistakes the timing of premium tax assessment. Provincial premium tax is deducted from the gross premium only when the client actually deposits a premium; during a premium pause, no new premiums enter, so no monthly premium tax is deducted from the account balance.

23 answer a

a. ✓ Correct. Actuarial parameters for the exemption test underwent a major overhaul on January 1, 2017, directly tying to policy generation classifications (G1, G2, and G3). Making changes such as increasing the face amount, converting policy types, or replacing the life insured on grandfathered policies issued on or before December 31, 2016, can cause the older policy to lose its grandfathered status and suffer generation demotion, permanently forfeiting its more generous tax-sheltered room.

b. ✗ Falls into the 'modal factor premium surcharge assumption' trap. Universal life insurance does not have a modal factor, and insurers will never retroactively charge one due to contractual changes.

c. ✗ Completely reverses cause and effect as well as scope. Failing the exemption test without timely correction results in the policy permanently losing its tax-exempt status (impacting its tax shelter), rather than automatically canceling the death benefit while retaining tax-sheltered savings.

d. ✗ Mixes unrelated concepts. The Bank of Canada's overnight policy rate of 2.25% belongs to the macroeconomic interest rate environment and has no bearing on a policy's adjusted cost basis (ACB) or grandfathered generation status under the exemption test.

23′ answer b

a. ✗ Conflates the exemption test with surrender charges. The maximum funding ceiling originates from statutory tax limits on tax-sheltered growth; excess funds are never forfeited or confiscated by the insurer.

b. ✓ Correct. Maximum funding is capped by the exemption test to demarcate protection benefits from excess investment growth, preventing universal life from becoming a pure tax shelter. Following comparison with a hypothetical benchmark policy on each policy anniversary, the insurer may reject, refund, or transfer excess deposits into an external taxable side fund, otherwise the policy risks permanently losing its tax-exempt status.

c. ✗ Makes two errors: the exemption test protects the government's tax base rather than client investment returns, and increasing the face amount generally requires medical underwriting rather than automatically granting coverage without evidence.

d. ✗ Makes two errors: first, contracts generally prohibit switching back from LCOI to YRT; second, whether utilizing YRT or LCOI, all universal life policies enjoying tax-sheltered growth must comply with the exemption test ceiling.

24 answer b

a. ✗ Falls into the 'illusion of low initial YRT pricing' trap. YRT is repriced annually based on attained age, causing costs to escalate sharply in later years (for example, reaching $54,521 in year 50); paying only minimum premiums on a permanent holding horizon will allow soaring late-life COI deductions to drain the account value.

b. ✓ Correct. The key criterion when selecting between YRT and level cost of insurance (LCOI) is the intended holding horizon. Because the client's goal is permanent estate planning and avoiding late-life cost spikes, LCOI actuarially levels mortality costs across the lifetime at issue (for example, locking in approximately $3,720 annually for life), perfectly matching permanent holding needs (the exam benchmark follows 'choose YRT for short-to-medium horizons, LCOI for permanent horizons'; practice at the point of sale also checks for adjustable-rate clauses and caps).

c. ✗ Reverses the conversion direction and cash value accumulation rates. Early cash value accumulates faster under YRT due to lower initial deductions, not under LCOI; furthermore, while some contracts permit switching from YRT to LCOI, switching back from LCOI to YRT is generally prohibited.

d. ✗ Conflates pricing structures with adjustable-rate clauses. YRT and LCOI feature completely different cost curves; moreover, certain universal life contracts permit insurers to adjust rates based on emerging claims experience, meaning open-ended contracts carry the risk of upward revisions even under LCOI.

24′ answer a

a. ✓ Correct. Yearly renewable term (YRT) costing is priced at younger attained ages in early years, resulting in low deductions that leave more premium in the accumulating fund for faster growth over a short-to-medium horizon (10 to 15 years); exam benchmarks also note that some policies permit converting from YRT to LCOI repriced at the attained age at conversion (point-of-sale practice must verify contract-specific conversion windows and maximum age limits).

b. ✗ Reverses cause and effect. Early LCOI deductions are substantially higher than YRT, absorbing funds that would otherwise enter the investment account, which results in slower cash value accumulation over the short-to-medium term (10 to 15 years) compared to YRT.

c. ✗ Incorrect conversion direction. Contract provisions generally permit only a one-way conversion from YRT to LCOI, and do not permit converting back from LCOI to YRT.

d. ✗ Conflates conversion repricing age. When requesting a conversion from YRT to LCOI, the level premium rate is repriced based on the life insured's attained age at the time of conversion, rather than their original issue age.

25 answer c

a. ✗ Falls into the 'inverting NAAR and death benefit options' trap. Under a level death benefit, account value growth directly reduces the net amount at risk (NAAR); only under level plus account value does NAAR remain constant at $500,000.

b. ✗ Completely inverts the mechanics of both death benefit options. Client Q is the one whose beneficiary receives the additional account value, which is why the insurer's net risk exposure on Client Q does not shrink.

c. ✓ Correct. Net amount at risk (NAAR) equals death benefit minus account value. Client P selected a level death benefit of $500,000, so subtracting the $120,000 account value reduces NAAR to $380,000, triggering the virtuous circle where account growth lowers mortality deductions; Client Q selected level plus account value, yielding a total payout of $500,000 + $120,000 = $620,000, which after subtracting the $120,000 account value leaves NAAR constant at $500,000, resulting in higher monthly deductions but a larger net death benefit.

d. ✗ Mistakes the minuend in the NAAR formula. NAAR equals the current total death benefit minus account value; under level plus account value, the total death benefit already includes the account value, so adding and subtracting cancel each other out, leaving NAAR unchanged.

25′ answer b

a. ✗ Falls into the 'inverting NAAR and death benefit options' trap. Under level death benefit plus account value, the net amount at risk (NAAR) does not decrease as the account grows, resulting in higher mortality deductions.

b. ✓ Correct. Under a level death benefit, the beneficiary receives only the fixed face amount, so every dollar of accumulating fund growth directly reduces the net amount at risk (NAAR) dollar for dollar, lowering periodic cost of insurance (COI) charges and making it ideal for clients wanting to minimize ongoing insurance costs during their lifetime.

c. ✗ Conflates investment account selection with death benefit options. Whether the virtuous circle lowers deductions by shrinking NAAR depends primarily on choosing a level death benefit structure.

d. ✗ Misattributes rules. Under a level death benefit, any account value growth immediately reduces the current net amount at risk (NAAR) from year one, without needing to wait until age 90.

26 answer d

a. ✗ Makes two errors: daily interest accounts (DIA) and guaranteed investment accounts (GIA) typically feature a 0% floor rather than the central bank's 2.25% policy rate, and surrendering during the first 5 to 10 years typically triggers a surrender charge.

b. ✗ Contradicts rules on both counts: credited returns in index–linked or fund–linked accounts do not confer direct legal ownership of underlying fund units, and surrender charges never exceed the current account value.

c. ✗ Invents unfounded restrictions. Both YRT and LCOI can allocate to all types of investment accounts; furthermore, surrender charges typically apply only during the first 5 to 10 years and decline annually, rather than persisting until age 100.

d. ✓ Correct. In universal life insurance, daily interest accounts (DIA) and guaranteed investment accounts (GIA, functioning similarly to GICs) typically have a 0% floor, whereas index–linked or fund–linked accounts can suffer losses; surrendering within the first 5 to 10 years incurs a declining surrender charge, calculated as a multiple of annual LCOI deductions and capped at the account value.

26′ answer a

a. ✓ Correct. In Canadian practice, Assuris acts as the policyholder protection organization for life and health insurance companies, protecting death benefits and cash values up to specified limits; while the exam manual does not mention Assuris (LKU–0042), an advisor at the counter cannot claim that insurers never fail, but must accurately explain the Assuris protection mechanism.

b. ✗ Conflates regulatory and guarantee frameworks. Even though guaranteed investment accounts (GIA) function similarly to bank GICs, universal life insurance remains a life insurance contract protected by the industry's Assuris mechanism, not bank deposit insurance.

c. ✗ Violates facts and professional conduct standards. All insurers carry theoretical solvency risks, and Canada established Assuris to provide insolvency protection; advisors must never misrepresent to clients that insurers are legally immune from failure.

d. ✗ Fabricates arbitrary conditions. The insolvency protection framework covers death benefits and cash values of eligible policies regardless of whether LCOI was selected or withdrawals were made.

27 answer c

a. ✗ Falls into the 'confusing leveraging with collateral assignment' trap. A policy loan legally constitutes a disposition under tax law (though no taxable gain arises here because the $30,000 loan does not exceed the $40,000 ACB), and regardless of loan type, any unpaid balance at death reduces the net payout to the beneficiary.

b. ✗ Erroneous in figures and legal character. Policy loans typically permit borrowing 50% to 90% of cash value (not 25%), and borrowing $30,000 against a $40,000 ACB generates no immediate taxable gain; collateral assignment serves merely as security for a loan rather than a permanent transfer of ownership.

c. ✓ Correct. Applying for a policy loan from the insurer (borrowing 50% to 90% of cash value) constitutes a disposition under tax law, but because the $30,000 loan does not exceed the $40,000 ACB, no immediate taxable gain arises, and unpaid principal and interest are deducted from the death benefit; a collateral assignment to a bank solely as loan security generally does not trigger a disposition, allowing the $120,000 cash value to compound tax–sheltered while the bank is entitled only to outstanding loan balances, resulting in substantive differences in net proceeds left to beneficiaries.

d. ✗ Inverts the funding source. Under a collateral assignment, the bank advances the loan funds, while the $120,000 in the accumulating fund is neither surrendered nor penalized, continuing to grow inside the policy.

27′ answer b

a. ✗ Conflates partial withdrawals, policy loan limits, and premium offset. A partial withdrawal is treated as a partial surrender that may trigger taxable income; 50% to 90% represents the borrowing limit for a policy loan.

b. ✓ Correct. Premium offset is one of the six rights of the accumulating fund: once account value has accumulated sufficiently, the policyholder may pause premium payments and rely on the internal cash value and investment earnings to cover future cost of insurance (COI) and admin charges, provided the account value remains sufficient to pay monthly deductions, failing which the policy may lapse.

c. ✗ Misattributes concepts. A collateral assignment pledges the policy as collateral for a third–party bank loan and has nothing to do with premium offset, where the policy pays its own deductions after premiums are paused.

d. ✗ Conflates leveraging with premium offset. Leveraging involves securing ongoing bank loans against the policy for retirement cash flow; it neither eliminates internal COI deductions nor protects against the risk of policy lapse or bank recourse from weak performance.

28 answer d

a. ✗ Falls directly into the 'modal factor premium surcharge assumption' trap. The 6% figure represents the annualized surcharge illustrative of monthly payments in term and traditional whole life exams; universal life insurance has no modal factor whatsoever.

b. ✗ Fabricates rules and figures out of thin air. The 10 to 15 year timeframe relates to short–to–medium holding horizons for YRT; universal life never charges a modal factor whether YRT or LCOI is chosen.

c. ✗ Cobbles together irrelevant figures. The $40,000 figure is the adjusted cost basis (ACB) amount from Case 3; the absence of a modal factor in universal life is a structural product feature, not contingent on any minimum deposit threshold.

d. ✓ Correct. Universal life insurance does not have a modal factor. Because universal life unbundles premiums so that actual cost of insurance (COI) and administration charges are deducted monthly or annually after funds enter the account, choosing monthly, quarterly, or semi–annual schedules produces the exact same annualized total as an annual payment, without generating the modal surcharge seen in traditional bundled products.

28′ answer b

a. ✗ Falls into the 'modal factor premium surcharge assumption' trap. Universal life has no modal factor, so quarterly deposits annualized produce the identical total as annual payments.

b. ✓ Correct. Accurately synthesizes two core principles: first, universal life has no modal factor, meaning annualized fractional deposits equal annual payments; second, periodic mortality charges (COI) are calculated from the net amount at risk (NAAR = death benefit minus account value) and applicable rates, rather than the face amount alone.

c. ✗ Falls into the 'inverting NAAR and death benefit options' trap. Only under a level death benefit does account value growth shrink the net amount at risk (NAAR); under level plus account value, NAAR remains constant at the fixed face amount.

d. ✗ Falls into the 'misjudging scope' trap. The exemption test limits the room for tax–sheltered deposits; losing tax–exempt status impacts the policy's tax treatment rather than automatically terminating the death benefit.

Chapter 5 answers and reasons

29 answer b

a. ✗ Incorrect. Falls into the Confusing Advances with Additional Payouts (Product Confusion) trap: It treats Victor's accelerated death benefit: dread disease (DD) as an additional payout, overlooking that DD is fundamentally an advance from the ultimate death benefit and must be deducted from the $50,000 face amount by the $25,000 received.

b. ✓ Correct. A dread disease (DD) benefit under an accelerated death benefit operates as a living advance mechanism, so the $25,000 Victor received reduces the ultimate death benefit dollar–for–dollar ($50,000 – $25,000 = $25,000); in contrast, Elena holds stand–alone critical illness (CI) insurance, which pays under an independent contract and never advances or reduces the $50,000 death benefit of her life insurance policy.

c. ✗ Incorrect. Falls into the Confusing Advances with Additional Payouts (Product Confusion) trap: It mistakenly assumes that stand–alone CI insurance reduces the life insurance death benefit like an accelerated death benefit; in reality, a stand–alone CI policy and a life insurance policy are parallel contracts that do not reduce each other.

d. ✗ Incorrect. Calculation error in the deducted amount: Victor advanced $25,000 under the 50% limit, so the death benefit is reduced only dollar–for–dollar by the $25,000 advance (leaving $25,000), rather than being reduced to $10,000.

29′ answer d

a. ✗ Incorrect. Falls into the Confusing Advances with Additional Payouts (Product Confusion) trap: A terminal illness (TI) benefit is an accelerated death benefit, which functions by advancing a portion of the future death benefit for use now rather than paying an extra sum in addition to the face amount.
b. ✗ Incorrect. Mistakenly assumes that receiving a partial advance voids the entire policy: The terminal illness (TI) benefit advanced only 50% ($25,000), leaving the remaining death benefit in force to be paid upon the insured's death.
c. ✗ Incorrect. Fabricates an administrative penalty rule: The terminal illness (TI) benefit is deducted dollar–for–dollar from the $50,000 face amount by the $25,000 actually advanced, without any fictitious 30% penalty.
d. ✓ Correct. A terminal illness (TI) benefit is a form of accelerated death benefit where the $25,000 paid to the policyholder represents an advance; upon the life insured's death, the final death benefit payable to the beneficiary is reduced dollar–for–dollar to $25,000.

30 answer c

a. ✗ Incorrect. Falls into the Mismatched Waiver Insured Parties (Provision Mismatch) trap: On a policy where Nadia is the life insured, a standard waiver of premium for total disability triggers only if Nadia herself becomes totally disabled; it provides no protection if Tariq, the payor, dies or becomes disabled, leaving nobody to pay premiums.
b. ✗ Incorrect. Falls into the Mismatched Waiver Insured Parties (Provision Mismatch) trap and ignores underwriting requirements: A standard waiver of premium for total disability does not automatically follow the payor, and any rider covering another party's risk requires underwriting on that specific individual.
c. ✓ Correct. When the policyholder/payor and the life insured are different persons, a parent/payor waiver benefit must be configured; because it triggers upon the death or disability of the payor (Tariq), Tariq himself must undergo underwriting.
d. ✗ Incorrect. Confuses product functions: An accidental death (AD) rider pays an additional death benefit only upon accidental death; it neither covers disability nor waives premiums on another policy.

30′ answer a

a. ✓ Correct. A textbook example of the Mismatched Waiver Insured Parties (Provision Mismatch) trap: The standard waiver of premium for total disability covers the disability of the life insured (Chloe); because the policyholder/payor (Grace) did not add a parent/payor waiver benefit, premiums are not waived when Grace becomes disabled.
b. ✗ Incorrect. Falls into the Mismatched Waiver Insured Parties (Provision Mismatch) trap: One cannot infer the covered party from policy ownership alone; only a parent/payor waiver benefit waives premiums upon the payor's disability until the child reaches a stipulated age (such as 18, 21, or 25).
c. ✗ Incorrect. Fabricates a compromise payout rule: When the covered party is mismatched, even if the payor satisfies a 6–month waiting period, the contract requirement of the life insured being disabled is not met, so the insurer will not waive any premiums.
d. ✗ Incorrect. Violates underwriting and contract law principles: A parent/payor waiver benefit requires medical underwriting on the payor at issue; contract provisions cannot be retroactively altered after a claim occurs.

31 answer a

a. ✓ Correct. Under exam conventions, a family/child coverage rider charges a flat rate per unit without increasing premiums for additional children; newborns must reach 15 days of age to be automatically covered (with no benefit if death occurs within the first 2 weeks), so a death at 10 days is not covered; before the rider expires at age 21 or 25, an impaired child may exercise the conversion privilege to obtain an individual permanent policy for up to 5 times the rider face amount (up to $50,000) without medical evidence.

b. ✗ Incorrect. Hits three separate errors: First, child riders charge a flat premium rather than charging per child; second, death occurring before 15 days (within the first 2 weeks) is not covered; third, the primary purpose of the conversion privilege is to protect an uninsurable child by granting permanent coverage without medical evidence.

c. ✗ Incorrect. Overlooks the 15–day waiting period for newborn coverage (a death at 10 days is not covered) and mistakenly assumes that converting up to 5 times the face amount requires evidence of insurability (conversion is guaranteed without evidence, and only amounts exceeding the contractual multiple require underwriting).

d. ✗ Incorrect. Misunderstands the pricing structure and falls into the Compressed Timeframe trap: Premiums do not increase with additional children, and the conversion privilege is exercised during a contractual window before expiry rather than exclusively on the exact expiration date.

31′ answer c

a. ✗ Incorrect. Overlooks the core insurability lock of the child rider conversion privilege: As long as it is exercised before rider expiry, even if the child became uninsurable at age 8, the insurer must issue the policy without evidence of insurability.

b. ✗ Incorrect. Confuses the conversion multiple limit: Since the contract allows conversion up to 5 times the rider face amount, the entire $50,000 ($10,000 x 5) qualifies for conversion without evidence of insurability; only amounts beyond 5 times would require standard underwriting.

c. ✓ Correct. Under the child rider conversion privilege, converting before expiry (before age 25) allows conversion to an individual permanent policy up to the insurer's 5–fold limit ($50,000) without medical evidence, with premiums calculated at standard rates for the attained age (22) without health ratings.

d. ✗ Incorrect. Falls into the 'terminology misreading' trap: it assumes that a conversion without underwriting can still carry a substandard health rating. The child rider conversion privilege promises standard rates priced at the attained age at conversion (age 22) and allows no extra loading for deteriorated health.

32 answer d

a. ✗ Incorrect. Falls into the 'GIB mistaken for free or anytime coverage (terminology and dual–benchmark misreading)' trap. The guaranteed insurability benefit (GIB) is neither triggered whenever the insured is diagnosed with an illness, nor does it lock in the original age–25 premium rate.

b. ✗ Incorrect. Contradicts the core function of the guaranteed insurability benefit (GIB), which is to lock in insurability. GIB exists precisely to hedge against deteriorating health, and when it is exercised on the contract's set anniversaries, no evidence of insurability (no medical exam) is required.

c. ✗ Incorrect. Falls into the 'terminology misreading' trap. The word 'guaranteed' in GIB means no evidence of insurability is needed, not that the coverage is free; the rider fee only buys the right to add coverage later, and the new coverage must be paid for with additional premium when it is actually added.

d. ✓ Correct. Under the exam standard, the guaranteed insurability benefit (GIB) is exercised on the contract's fixed anniversaries (such as the 5th and 10th) and is subject to single and cumulative limits (although some current market products also allow exercise within 31 days of graduation, marriage, birth, or adoption, the exam still answers with fixed anniversaries plus financial limits); no evidence of insurability is required, and the premium is calculated at standard rates for the insured's attained age at exercise.

32′ answer b

a. ✗ Incorrect. Confuses the 1–year time limit of the accidental death (AD) rider with the GIB application deadline, and falls into the 'terminology misreading' trap. Although newer GIB provisions relax the triggers, the application deadline is strictly limited to 31 days, and the premium is calculated at the attained age when the coverage is added.
b. ✓ Correct. In practice, newer guaranteed insurability benefit (GIB) provisions relax the trigger from fixed anniversaries to life events such as graduation, marriage, childbirth, and adoption (note: generic exam questions still answer on fixed anniversaries), but the application deadline is not relaxed: the advisor must submit it within 31 days after the event or the relevant anniversary, and the new coverage is priced at the attained age at exercise.
c. ✗ Incorrect. Misapplies the 15–day newborn waiting period from child riders to GIB and mistakenly assumes that GIB coverage additions require no new premium (Terminology Misinterpretation).
d. ✗ Incorrect. Confuses the 30–day survival waiting period for dread disease (DD) with the 31–day notification window for GIB, and violates the core GIB mechanism waiving evidence of insurability.

33 answer b

a. ✗ Incorrect. Inverts the primary–secondary relationship and underwriting rules: Cheng still undergoes underwriting once for both the base policy and rider (rather than waiving underwriting entirely), and after 10 years only the term insurance rider expires while the whole life base policy remains in force.
b. ✓ Correct. Combining a whole life base policy with a term insurance rider to cover a 10–year temporary need collapses duplicate underwriting costs and two annual policy fees (typically $50 to $100 each) into one; once the loan is paid off in 10 years, the term rider expires and its premium ceases, while the whole life base policy remains in force for life.
c. ✗ Incorrect. Confuses coverage attributes: A term insurance rider provides temporary pure protection for a limited term, accumulates no cash value, and terminates upon expiry after 10 years rather than converting into permanent insurance free of charge.
d. ✗ Incorrect. Falls into the Treating Riders as Standalone Policies (Category Mismatch) trap: A term insurance rider trades independence for a lower bundled price and depends strictly on the base policy; if the whole life base policy is cancelled or surrendered in year 5, the term rider terminates simultaneously.

33′ answer c

a. ✗ Incorrect. Falls into the Treating Riders as Standalone Policies (Category Mismatch) trap: Although a term insurance rider has its own 10–year term, it is not an independent policy and cannot survive on its own apart from the base policy.
b. ✗ Incorrect. Falls into the Treating Riders as Standalone Policies (Category Mismatch) trap: A rider's dependency is dictated by contract structure; once the base policy lapses, the rider cannot be maintained independently by paying the $50 to $100 annual policy fee.
c. ✓ Correct. The primary constraint of a term insurance rider is dependency: riders trade independence for bundled savings, so if the base policy lapses for non–payment or is surrendered, attached term riders terminate immediately.
d. ✗ Incorrect. Fabricates conversion rules: A term insurance rider cannot be converted into an accidental death (AD) rider to circumvent the consequences of a base policy lapse.

34 answer a

a. ✓ Correct. A core principle of needs analysis (value of coverage) is that survivors' capital needs do not change depending on whether death is caused by an accident or an illness, so the coverage gap must be fully covered by the base policy rather than supplemented with an accidental death (AD) rider; furthermore, a heart attack is an illness rather than an accident, so double indemnity is not triggered and the beneficiary receives only the $300,000 base death benefit.

b. ✗ Incorrect. Falls into the Scope Inflation trap: An accidental death (AD) rider strictly distinguishes external accidental causes from internal illnesses; a sudden heart attack is a death from illness and never triggers double indemnity.

c. ✗ Incorrect. Reverses the time limitation for an accidental death (AD) rider: The rider requires that death be caused by an accident and occur within a specified timeframe following the accident (commonly within 1 year), not after 1 year.

d. ✗ Incorrect. Confuses coverage boundaries: An accidental death (AD) rider and a dread disease (DD) benefit are entirely separate provisions; the AD rider does not transform into a critical illness payout simply because the cause of death is a Big 4 illness.

34′ answer d

a. ✗ Incorrect. Overlooks contractual exclusions under the accidental death (AD) rider: Although death occurred within the 1–year limit, accidents resulting from criminal acts are explicitly excluded.

b. ✗ Incorrect. Fabricates a proportional reduction rule: Once an exclusion is triggered, the accidental death (AD) rider denies the claim entirely; no partial or prorated payout exists.

c. ✗ Incorrect. Misapplies the 15–day newborn waiting period from child riders to an adult vehicular collision claim, confusing provisions between completely different riders.

d. ✓ Correct. Contracts for accidental death (AD) riders explicitly list suicide, self–inflicted injury, war, and criminal acts as exclusions; because Julian died in a vehicle crash while fleeing a crime, the AD rider pays no benefit even though death occurred within the 1–year timeframe.

35 answer c

a. ✗ Incorrect. Overlooks third–party underwriting rules: When a term insurance rider covers someone other than the base life insured (such as spouse Rachel), that individual must undergo separate underwriting.

b. ✗ Incorrect. Falls into the Cost of Coverage Misunderstanding trap: A waiver of premium for total disability is not necessarily free; in many contracts, it is an optional rider requiring an additional premium.

c. ✓ Correct. Underwriting rules dictate that while a term rider on the primary insured typically shares base policy underwriting, a term rider covering a spouse or third party (Rachel) requires separate underwriting on that individual; additionally, pricing cannot be deduced from feature names alone, as waiver of premium may carry an extra premium and each cost must be verified on the quote.

d. ✗ Incorrect. Fabricates an underwriting prohibition: A term insurance rider or family rider can cover a spouse, provided that the spouse separately satisfies contract underwriting requirements.

35′ answer b

a. ✗ Incorrect. Falls into the Cost of Coverage Misunderstanding trap: One cannot assume pricing structure based solely on whether an item is labelled a rider or a supplementary benefit.

b. ✓ Correct. Cost of coverage cannot be judged by labels like rider or supplementary benefit: some terminal illness (TI) benefits are built into the base contract (with costs absorbed into the base premium), while waiver of premium often requires an additional optional charge; advisors must itemize base premiums, optional rider fees, and built–in features separately on quotes.

c. ✗ Incorrect. Falls into the Cost of Coverage Misunderstanding trap: Waiver of premium is an optional, fee–bearing benefit in most published product guides, rather than universally free.

d. ✗ Incorrect. Confuses the annual policy fee ($50 to $100) with built–in coverage costs: Costs for built–in benefits are already included in the base premium, and insurers do not charge duplicate annual policy fees for each built–in provision.

Chapter 6 answers and reasons

36 answer b

a. ✗ Falls into the 'inverting tax treatment across insurance lines' trap. Incorrectly applies the group wage loss replacement plan (WLRP) rule of taxing benefits at payout to group life insurance, and erroneously splits the life insurance death benefit based on premium contribution proportions.

b. ✓ Correct. Under group life insurance, the $600 premium paid by the employer is included in the employee's taxable income for the year as a taxable benefit; the $600 paid by the employee is not deductible and generates no taxable benefit; and the life insurance death benefit principal (2 times annual salary, or $220,000) is generally exempt from income tax in full regardless of who paid the premiums.

c. ✗ Falls into the 'assuming employee contributions are tax–deductible' trap. The portion of group life insurance premiums paid by the employee cannot be deducted on personal income tax returns.

d. ✗ Falls into the 'assuming only 100% employee–funded plans yield tax–free death benefits' trap. Group life insurance death benefit principal is inherently exempt from income tax regardless of who pays the premiums; paying 100% of the premium simply eliminates the taxable benefit at the premium payment stage rather than altering the tax–free status of the death benefit itself.

36′ answer c

a. ✗ Falls into the 'assuming 100% employee payment confers tax deductibility' trap. Employee–paid group life insurance premiums are not tax–deductible; paying them directly merely prevents a taxable benefit from arising.

b. ✗ Falls into the 'cross–product tax confusion' trap. Premiums paid by the employee do not create a taxable benefit, and the employer funding a separate disability plan in no way makes the group life insurance death benefit taxable.

c. ✓ Correct. When an employee pays 100% of group life insurance premiums, the premium is not deductible and creates no taxable benefit; the life insurance death benefit principal ($150,000) is generally exempt from income tax in full whether paid by the employer or the employee.

d. ✗ Falls into the 'proportional death benefit taxation' trap. The life insurance death benefit principal is generally fully tax–free and is never apportioned or taxed based on overall benefit package cost–sharing ratios.

37 answer a

a. ✓ Correct. Under the conversion privilege and CLHIA Guideline G3 standards, members in non–Quebec provinces whose coverage terminates before age 65 can convert to an individual policy within 31 days without evidence of insurability, capped at the lesser of $200,000 or the prior group coverage amount (Tariq's $150,000 coverage is below $200,000, allowing full conversion); the application and first modal premium must be submitted within the window, and premiums are recalculated based on his attained age.

b. ✗ Falls into the 'treating the $200,000 conversion cap as a fixed or guaranteed floor' trap. The $200,000 figure is the maximum limit for non–medical conversion (the lesser of $200,000 or original coverage); Tariq's $150,000 prior coverage cannot be increased to $200,000 through the conversion privilege.

c. ✗ Falls into the 'assuming verbal notice is sufficient and premiums remain level' trap. The member must submit an application and pay the first premium in full to the insurer within the 31–day window (rather than merely stating an intention), and the converted individual policy is priced at attained age, which is typically significantly higher than the group rate.

d. ✗ Falls into the 'overlooking the core non–medical value of the conversion privilege' trap. The essential purpose of the conversion privilege is to guarantee coverage within specified limits and the 31–day window without evidence of insurability, meaning the insurer cannot decline coverage due to his deteriorated health.

37′ answer d

a. ✗ Falls into the 'exceeding the conversion cap and confusing the window duration' trap. Conversion without evidence of insurability cannot exceed the $200,000 cap, and the standard conversion window is 31 days rather than 60 days.

b. ✗ Falls into the 'misapplying Quebec limits' trap. The $400,000 limit applies strictly to Quebec; in non–Quebec jurisdictions such as BC, the non–medical conversion cap is $200,000 and cannot exceed the prior group face amount.

c. ✗ Falls into the 'overlooking the requirement to pay the first premium within the window' trap. Both the completed application and the first premium payment must be finalized within the 31–day window.

d. ✓ Correct. Sonia's original coverage of $320,000 exceeds the non–Quebec non–medical conversion cap of $200,000, so under the conversion privilege rule the lesser of the two applies, so she can convert at most $200,000 without evidence of insurability, provided both the application and first modal premium arrive within the 31–day window.

38 answer c

a. ✗ Falls into the 'narrowing eligible plan sponsors' trap. Beyond corporate employers, professional associations, alumni groups, chambers of commerce, and other affinity groups sharing common characteristics recognized by insurers can act as plan sponsors to hold a group master contract.

b. ✗ Falls into the 'assuming the benefit booklet is the master contract and signed by members' trap. The master contract contains the actual terms and is executed between the plan sponsor and the insurer, whereas the benefit booklet is merely an explanatory summary.

c. ✓ Correct. Exam references contrasting Quebec rules must not be construed as meaning BC lacks this right: the association holds the master contract setting the governing terms as the plan sponsor, and under BC Insurance Act s41(5)(b) and s41(7), a group life insured is entitled upon reasonable notice to inspect and obtain a copy of the group policy from the insurer, with the first copy provided free of charge.

d. ✗ Falls into the 'falsely inferring BC lacks inspection rights from Quebec descriptions' trap. BC Insurance Act s41(5)(b) and s44 explicitly grant group insured individuals and claimants the right to inspect and obtain copies of the master policy, subject to reasonable notice, privacy protections, and claim relevance limits.

38′ answer a

a. ✓ Correct. While exam materials cite Quebec statutory rules, BC Insurance Act s41(5)(b) explicitly provides that a group life insured or claimant may inspect and obtain a copy of the group master contract from the insurer on reasonable notice, with s41(7) establishing that the first copy is free, and s41(9) limiting a claimant's inspection scope to information relevant to the claim or denial.

b. ✗ Falls into the 'assuming non-policyholders have no statutory inspection rights' trap. The BC Insurance Act directly grants group insured persons and claimants the statutory right to request inspection and copies from the insurer.

c. ✗ Overlooks statutory privacy safeguards under BC Insurance Act s41(8) and s41(9), which protect third-party confidentiality and restrict a claimant's entitlement strictly to information relevant to the claim or denial.

d. ✗ Falls into the 'confusing the benefit booklet with the master contract' trap. The benefit booklet is merely an informational summary, whereas the master contract is the governing policy document executed between the plan sponsor and the insurer.

39 answer b

a. ✗ Simultaneously overlooks the actively-at-work requirement for new coverage and the underwriting rules governing optional additional coverage applied for outside the open enrolment window.

b. ✓ Correct. After completing the 3-month probationary period, coverage commencement depends on whether the member satisfies the contract's actively-at-work requirement; furthermore, to prevent adverse selection from individuals applying only after health declines, optional additional coverage requested after the open enrolment window (60 days in the exam example) requires medical underwriting.

c. ✗ The actively-at-work requirement affects when coverage takes effect rather than resetting the probationary period; similarly, members who miss the non-medical window can still apply for optional coverage subject to medical underwriting rather than facing a permanent bar.

d. ✗ Falls into the 'misunderstanding adverse selection mechanics' trap. Basic group life coverage amounts are strictly set by plan terms precisely to control adverse selection, leaving members with virtually no discretion over basic benefit amounts.

39′ answer a

a. ✓ Correct. Basic group coverage is issued without medical evidence because pricing relies on the law of large numbers and group-wide risk characteristics; if members could freely select high coverage amounts or wait until their health deteriorated beyond the initial window (such as 60 days) to add non-medical coverage, adverse selection would destroy actuarial balance.

b. ✗ Falls into the 'cross-line concept conflation' trap. The all-source maximum offset is a coordination clause unique to group disability income plans; group life insurance death benefits are subject to no such offset.

c. ✗ Fabricates tax rules. The BC provincial premium tax rate for licensed insurers is 2%, while 9% represents Quebec's sales tax rate in the exam comparison tables.

d. ✗ Predetermined benefit schedules are designed to control adverse selection within the group plan, but they do not prohibit employees from obtaining individually underwritten life insurance policies on the retail market.

40 answer b

a. ✗ Falls into both the 'missing the 14–day eligibility threshold' and 'per–head dependant premium surcharge' traps. Exam rules establish that dependant children qualify starting at 14 days of age (a 10–day–old newborn does not yet qualify), and a flat family premium does not increase with each additional eligible child.

b. ✓ Correct. Under exam rules, eligible dependants are covered from 14 days of age up to age 18, 19, or 21, extendable to age 23 to 25 for full–time students (the 16–year–old and 22–year–old student qualify, but the 10–day–old newborn does not); because both a spouse and eligible children are covered, spousal AD&D is 40% of the member's face amount ($200,000 x 40% = $80,000); and survivor income benefits are paid monthly until the spouse reaches age 65, remarries, or dies.

c. ✗ Falls into both the 'mismatched AD&D percentage' and 'treating survivor income as a death benefit deduction' traps. When eligible children are also covered, the spousal AD&D percentage drops to 40% ($80,000) rather than the 50% ($100,000) applicable with no children; furthermore, survivor income benefits are monthly supplements paid in addition to the death benefit and are not deducted from the lump sum.

d. ✗ Full–time post–secondary students can remain eligible dependants up to age 23 to 25; moreover, practice requires verifying whether dependants exist and whether family coverage is selected, rather than assuming single employees without dependants must pay the flat family rate.

40′ answer a

a. ✓ Correct. Survivor income benefits are monthly income supplements paid on top of the lump–sum death benefit, continuing for the spouse until age 65, remarriage, or death; because Grace has a spouse but no children, the spouse's dependant AD&D is 50% of Grace's coverage, or $150,000 x 50% = $75,000.

b. ✗ Survivor income benefits are paid monthly rather than as a lump sum; furthermore, when there are no children, the spousal AD&D percentage is 50% ($75,000) rather than the 40% ($60,000) that applies when children are covered.

c. ✗ Survivor income benefits are an ancillary benefit under group life insurance and are payable upon death from illness or injury, not restricted solely to accidental death.

d. ✗ Spousal survivor income benefits terminate upon reaching age 65, remarriage, or death, rather than continuing for life after remarriage; additionally, 15% ($22,500) represents the benefit percentage per eligible child, not the spouse.

41 answer d

a. ✗ Falls into the 'treating one insurer's age 65 guideline as an industry–wide ban and prematurely urging early retirement' trap. A retirement date affects pensions and employment benefits, so an advisor must never advise a client to retire early based solely on an insurance conversion rule.

b. ✗ Simultaneously falls into three traps: overlooking the $200,000 conversion cap and the resulting $40,000 coverage gap, ignoring contract boundary differences on the 65th birthday, and ignoring the complete termination of retiree coverage at age 70.

c. ✗ Falls into the 'treating group term life coverage reductions as cash value payouts' trap. Age–banded reductions under a group term schedule of benefits represent downward coverage adjustments and generate no cash surrender value or living benefit.

d. ✓ Correct. The exam material states that the conversion privilege applies 'before or at age 65,' whereas some insurer guidelines exclude coverage terminating on or after the 65th birthday; the advisor should obtain written contract provisions before retirement to verify the interaction among the final working day, retirement date, and coverage termination date, while comparing retiree continuation (terminating at age 70), the $200,000 non–medical conversion cap (noting the $40,000 gap from his $240,000 coverage), and alternative eligible products, without urging early retirement based solely on insurance rules.

41′ answer b

a. ✗ Falls into the 'ignoring late–age coverage reduction and termination rules' trap. Group life coverage for retired or senior members almost always reduces in stages and typically terminates completely at a specified age, such as age 70 in the exam examples.

b. ✓ Correct. Dual–benchmark distinction: in exam scenarios without specific contract variations, apply the exam standard of 'before or at age 65' up to the $200,000 non–medical conversion cap; in practice, some insurer guidelines exclude terminations on or after the 65th birthday, and any original coverage exceeding $200,000 (a $20,000 gap on $220,000) requires separate planning.

c. ✗ Age–banded coverage reductions under a schedule of benefits merely decrease the death benefit; group term life insurance carries no cash value or cash surrender payout.

d. ✗ The non–Quebec non–medical conversion cap is the lesser of $200,000 or the prior group coverage, and this $200,000 ceiling is never waived for members over age 60.

42 answer c

a. ✗ Falls into both the 'assuming plan changes wipe out existing premium waivers' and 'confusing loss of eligibility with benefit reduction' traps. For a member on an approved disability waiver of premium, coverage and premium waiver continue or are apportioned between contracts despite employer changes; seasonal drivers whose membership class was eliminated lose plan eligibility entirely rather than retaining 50% coverage.

b. ✗ Falls into the 'reversing creditor insurance parties and beneficiary directions' trap. Under group creditor insurance, the lending financial institution is the master policyholder, the borrower is the group member, and the death benefit equals the outstanding loan balance and is applied to pay off the debt.

c. ✓ Correct. For members with an approved disability waiver of premium, coverage and waiver rights must continue across insurer replacements or terminations, with liability allocated between contracts; members whose class is eliminated lose eligibility under the new plan and must receive notice to evaluate conversion or continuation options; the exam cites CLHIA Guideline G7 section 6(d) providing a 20–day full refund window after receipt of certificate (distinct from the 10–day cooling–off period under individual life Guideline G10), while current public sources confirm only G7's scope and statutory priority, requiring verification against the active group contract.

d. ✗ The exam cites conversion window durations of 31 days (in two places) and 30 days (in one place), never 45 days; furthermore, replacement contracts when switching insurers are designed to ensure continuous coverage for active eligible members without coverage gaps.

42′ answer a

a. ✓ Correct. Under group creditor insurance, the financial institution is the policyholder and the borrower is the group member, with the death benefit equaling the outstanding loan balance; the exam cites CLHIA Guideline G7 providing a 20–day refund window upon receipt of the certificate (current public sources confirm scope while actual practice requires verifying the active contract); and a member on an approved disability waiver of premium retains continuous coverage and waiver protection even if the employer terminates the master contract.

b. ✗ The policyholder of group creditor insurance is the lending institution rather than Paul; additionally, a member on an approved disability waiver of premium does not lose coverage immediately upon termination of the employer's master policy.

c. ✗ Group creditor life death benefits equal the outstanding loan balance (declining as the loan is paid down) rather than remaining level; and the 10–day cooling–off period belongs to individual life insurance under Guideline G10, which must not be confused with creditor group insurance under Guideline G7.

d. ✗ A disability waiver of premium never requires the member to repay previously waived premiums when the plan terminates, and coverage and waiver liabilities must continue under the governing terms.

Chapter 7 answers and reasons

43 answer a

a. ✓ Correct. First calculate the adjusted cost basis (ACB): cumulative premiums ($50,000) minus cumulative net cost of pure insurance (NCPI of $16,000) equals $34,000. Next, calculate the policy gain: proceeds of disposition (CSV of $64,000) minus ACB ($34,000) equals $30,000. Policy gains are 100% included in taxable income, so at Clara's 30% marginal tax rate, tax payable is $30,000 x 30% = $9,000.

b. ✗ Falls into the 'applying the 50% capital gains inclusion rate to policy gains' trap. Life insurance surrenders generate policy gains, which must be 100% included in taxable income and do not qualify for the 50% capital gains inclusion rate.

c. ✗ Falls into the 'mistaking cumulative premiums for ACB' trap. Erroneously treats cumulative premiums of $50,000 as the ACB without deducting cumulative NCPI of $16,000, thereby understating the taxable policy gain.

d. ✗ Confuses death benefits with a lifetime surrender disposition. An exempt policy is only exempt from annual accrual taxation during policy accumulation; surrendering the policy for cash requires tax to be paid on the excess of proceeds over ACB.

43′ answer c

a. ✗ Fails to deduct cumulative NCPI ($9,000) from cumulative premiums ($32,000), mistakenly calculating the ACB as $32,000.

b. ✗ Falls into the 'applying the 50% capital gains inclusion rate to policy gains' trap. Mistakenly includes the $15,000 policy gain at 50% as a capital gain; policy gains must be 100% included in taxable income.

c. ✓ Correct. The ACB is $32,000 – $9,000 = $23,000. The policy gain is $38,000 – $23,000 = $15,000. Policy gains are 100% included in taxable income, so at Owen's 40% marginal tax rate, tax payable is $15,000 x 40% = $6,000.

d. ✗ Simultaneously fails to deduct the ACB ($23,000) and incorrectly applies a 50% capital gains inclusion rate to the entire cash surrender value.

44 answer b

a. ✗ Determining whether a policy loan produces a taxable policy gain requires comparing the loan amount to the adjusted cost basis (ACB of $14,000), not to the cash surrender value (CSV of $60,000).

b. ✓ Correct. A policy loan is a disposition under tax law: the loan amount of $20,000 exceeds the ACB of $14,000 by $6,000, creating a taxable policy gain that is 100% included in income, and reducing the ACB to $0. Additionally, interest deductibility depends on the use of borrowed funds; because the loan funds personal wedding expenses rather than earning taxable income, the interest is not deductible.

c. ✗ Falls into the trap of conflating loan principal taxation with loan interest deductibility. These are separate determinations; interest on funds used for personal consumption never becomes tax–deductible simply because the principal triggered a taxable policy gain.

d. ✗ The $6,000 excess over ACB is a policy gain, which is 100% included in taxable income rather than included at 50% as $3,000, and taking the loan reduces the ACB to $0 rather than leaving it at $14,000.

44′ answer a

a. ✓ Correct. Although a policy loan is a disposition, the $15,000 loan is less than the $19,000 ACB, so no taxable policy gain arises and the ACB is reduced dollar–for–dollar to $19,000 – $15,000 = $4,000. Because the borrowed funds are used to earn taxable rental income and verified on Form T2210, the policy loan interest is deductible.

b. ✗ A policy loan is a disposition, but when the loan amount does not exceed the ACB ($15,000 <= $19,000), it merely reduces the ACB and produces no taxable policy gain.

c. ✗ The absence of a taxable gain does not mean no disposition occurred; borrowing up to ACB is still a disposition and must reduce the ACB from $19,000 to $4,000.

d. ✗ Falls into the 'policy loan interest is never deductible' trap. When policy loan proceeds are used to earn taxable investment income (such as rent or dividends, rather than solely capital gains) and verified by the insurer on Form T2210 without being added to ACB, the interest is tax–deductible.

45 answer c

a. ✗ Falls into the trap of treating a collateral assignment as a full surrender or non–arm's–length absolute assignment. A collateral assignment does not trigger a disposition, so no calculation of CSV minus ACB is required.
b. ✗ Confuses assigning a policy to a bank as collateral with taking a policy loan from an insurer. The difference between a bank loan and the policy ACB does not create a policy gain.
c. ✓ Correct. Assigning a policy as collateral security for a loan is not a disposition under tax law; as long as the policy remains exempt, cash value growth continues to accumulate tax–deferred.
d. ✗ Assigning a policy to a lender as collateral security has no effect on the annual exempt test and does not cause the policy to become non–exempt.

45′ answer b

a. ✗ An absolute assignment transfers legal ownership of the policy, which is completely distinct from a collateral assignment pledged as security, and triggers an immediate disposition.
b. ✓ Correct. An absolute assignment of a policy to an unrelated third party in an arm's–length sale constitutes a disposition: proceeds of disposition equal the actual consideration ($65,000), minus the pre–transfer ACB ($25,000), generating a $40,000 policy gain that is 100% included in taxable income.
c. ✗ Falls into the 'extending rollovers to business partners' trap. An inter vivos tax–free rollover at ACB applies strictly to qualifying spouses/common–law partners or direct transfers to children, and is never available between unrelated business partners.
d. ✗ The gain resulting from disposing of a life insurance policy is a policy gain, which must be 100% included in taxable income and cannot use the 50% capital gains inclusion rate.

46 answer d

a. ✗ The $1,000,000 death benefit received by the corporation is fully tax–free; the presence of a $150,000 ACB does not make corporate receipt taxable, but only limits the amount credited to the CDA.
b. ✗ Falls into the double trap of assuming the entire death benefit enters the CDA and distributes tax–free automatically. The credit to the CDA must be net of the policy's $150,000 ACB, and paying a capital dividend requires filing Form T2054.
c. ✗ Reverses the CDA calculation: the amount credited to the CDA is the death benefit minus ACB ($850,000), while the portion equal to the ACB ($150,000) does not credit the CDA.
d. ✓ Correct. The corporation receives the $1,000,000 death benefit entirely tax–free. The amount credited to the capital dividend account (CDA) is the death benefit minus the ACB: $1,000,000 – $150,000 = $850,000. Under ITA s.83(2), to distribute this CDA balance as a tax–free capital dividend, the corporation must file Form T2054 on or before the earlier of when the dividend becomes payable or is paid.

46′ answer b

a. ✗ Falls into the trap of assuming term insurance always has an ACB of zero. Having no cash surrender value does not mean the ACB is zero; when the insurer reports an ACB of $18,000, that amount must be deducted when determining the CDA credit.
b. ✓ Correct. For both permanent and term life insurance, the credit to the capital dividend account (CDA) equals the death benefit minus the insurer–reported ACB: $600,000 – $18,000 = $582,000.
c. ✗ Confuses life insurance proceeds entering the CDA with the rule crediting the 50% non–taxable portion of capital gains to the CDA. The excess of a life insurance death benefit over ACB credits the CDA at 100% ($582,000).
d. ✗ Corporate–owned term life insurance death benefits qualify for the capital dividend account mechanism, and the $582,000 excess over ACB credits the CDA as normal.

47 answer a

a. ✓ Correct. When both spouses are Canadian tax residents, an inter vivos transfer automatically rolls over at the $18,000 ACB under ITA s.148(8.1) by default with zero immediate gain. However, David can elect out of the rollover, causing proceeds of disposition to be deemed $70,000 under s.148(7), triggering a $52,000 policy gain to offset his current business loss while bumping Karen's inherited ACB up to $70,000.

b. ✗ Reverses the default rule and election requirements: the spousal rollover applies automatically by default when statutory conditions are met, and only electing out of the rollover requires an affirmative election.

c. ✗ Under ITA s.148(8.1), the transferor is permitted to elect out of the automatic spousal rollover to utilize current losses against policy gains and step up the recipient spouse's ACB.

d. ✗ Even when electing out of the rollover, the resulting $52,000 gain is a life insurance policy gain, which must be 100% included in taxable income rather than included at 50% as a capital gain.

47′ answer d

a. ✗ A transfer to a child for no consideration must be made directly to the child; transferring a policy into a family trust does not qualify for the intergenerational rollover under ITA s.148(8).

b. ✗ Transferring the policy to a legal guardian acting as a trustee fails the statutory condition of transferring ownership directly to the child, disqualifying it from the s.148(8) ACB rollover.

c. ✗ The child rollover under s.148(8) requires an inter vivos transfer for no consideration; selling the policy for fair market value consideration does not qualify for a tax–free rollover at ACB.

d. ✓ Correct. Under ITA s.148(8), where a non–annuity policy insures the life of the transferor's or transferee's child and is transferred directly to the child for no consideration, it rolls over at the $12,000 ACB; Leo himself or his adult sister (who is also Grace's child) qualifies as a valid transferee.

48 answer b

a. ✗ Only life insurance proceeds with a valid named beneficiary bypass the estate and avoid probate fees; when no beneficiary is named and proceeds fall into the estate, probate fee exemption is forfeited.

b. ✓ Correct. Because no beneficiary was named, proceeds enter the estate and attract BC probate fees. Since other estate assets already exceed the $50,000 threshold, the entire $300,000 attracts the rate of $14 per $1,000 (which is identical between the exam syllabus and 2026 current rules), calculating as ($300,000 / $1,000) x $14 = $4,200.

c. ✗ The $6 per $1,000 rate applies strictly to the estate value tier between $25,000 and $50,000; values exceeding $50,000 are subject to $14 per $1,000.

d. ✗ Confuses probate fees with income taxes. The death benefit principal of an ordinary exempt policy remains non–taxable for income tax purposes even if paid into the estate, but simply loses the exemption from probate fees.

48′ answer a

a. ✓ Correct. Specifying a valid named beneficiary (even a niece) allows the death benefit to be paid outside the estate directly to the beneficiary, bypassing BC probate and avoiding probate fees, while the principal is received tax–free.

b. ✗ Bypassing the probate process requires only a valid named beneficiary; there is no statutory requirement that the beneficiary designation be irrevocable or restricted to a spouse or child.

c. ✗ The death benefit principal of an exempt life policy is non–taxable to any named beneficiary, and naming a niece rather than a spouse does not make 50% of the payout taxable.

d. ✗ A named beneficiary claims proceeds directly from the insurer without applying to court for probate, paying neither the proportional probate fee nor the flat court filing fee ($208 in the exam syllabus versus $200 currently).

49 answer c

a. ✗ Falls into the asset eligibility trap: general commercial partnership interests do not qualify for the LCGE, with exceptions restricted strictly to qualified family farm or fishing partnerships.
b. ✗ The lifetime capital gains exemption (LCGE) applies solely to capital gains on qualified small business corporation (QSBC) shares or qualified farm and fishing property, and can never shelter life insurance policy gains.
c. ✓ Correct. Under the 2022 exam syllabus, the lifetime capital gains exemption (LCGE) limit for qualified small business corporation (QSBC) shares is $913,630, and general partnership interests do not qualify (note: under 2026 current rules, the LCGE limit is $1,275,000, providing a cumulative deduction of $637,500 at a 50% inclusion rate; exam candidates must follow the syllabus figures provided in the question stem).
d. ✗ Shares of any Canadian private corporation do not automatically qualify for the LCGE without verifying statutory holding period and active business asset tests.

49′ answer a

a. ✓ Correct. Qualifying family farm or fishing partnership interests qualify as eligible property with a 2026 current LCGE limit of $1,275,000 (compared to the 2022 exam syllabus figure of $913,630); under current ITA s.38(a), the general capital gains inclusion rate remains 50%; and life insurance policy gains are 100% included in taxable income and cannot be sheltered by the LCGE.
b. ✗ While general commercial partnerships do not qualify, eligible family farm or fishing partnerships constitute qualifying property; furthermore, policy gains are 100% included in income rather than at 50%.
c. ✗ The $1,250,000 limit was the 2025 figure and was indexed to $1,275,000 for 2026; furthermore, life insurance policy gains are not capital gains and cannot be sheltered by the LCGE.
d. ✗ The 2024 proposal to raise the inclusion rate to two-thirds was repealed in March 2025, leaving the current ITA s.38(a) general capital gains inclusion rate at 50%, while policy gains are consistently included at 100%.

Chapter 8 answers and reasons

50 answer a

a. ✓ Correct. A demand loan does not require a borrower default or a fixed maturity date; the lender may demand repayment under the loan terms and applicable notice rules. When a policy is assigned as collateral security to a restricted financial institution and satisfies ITA s.20(1)(e.2), the business may deduct the portion of the lesser of the annual premium and the net cost of pure insurance (NCPI) that reasonably corresponds to the debt outstanding ($800,000 / $1,000,000).
b. ✗ Falls into the 'believing a demand loan is safe before maturity' trap. A demand loan can be called under its terms upon proper notice even without default. Furthermore, assigning a policy to a bank as collateral is a collateral assignment rather than an absolute transfer and does not trigger a policy disposition.
c. ✗ Demand rights must still be exercised under the contractual terms and applicable notice conditions. Moreover, premium deductions are capped at the lesser of annual premium and NCPI prorated to the loan balance, rather than allowing a 100% deduction simply because a business loan exists.
d. ✗ The deduction base is the lesser of the annual premium and NCPI (not NCPI alone), and the deductible fraction represents the debt outstanding relative to the policy face amount, rather than inverting the ratio to face amount over loan balance.

50′ answer c

a. ✗ A collateral assignment is not an absolute assignment and does not trigger a disposition; furthermore, a commercial demand loan is not bound by equipment depreciation schedules.

b. ✗ Cash surrender value growth inside an exempt life insurance policy continues to accumulate tax–deferred, rather than serving as a deductible expense item.

c. ✓ Correct. A demand loan may be called by the lender under its terms upon a key person's death, triggering a corporate liquidity crisis. Under ITA s.20(1)(e.2), a collateral assignment allows the company to deduct the portion of the lesser of the premium and NCPI that reasonably corresponds to the $450,000 loan ($450,000 / $900,000).

d. ✗ The company cannot deduct the entire annual premium simply because a loan exists; it must calculate the deduction from the lesser of premium and NCPI prorated to the loan balance relative to coverage.

51 answer b

a. ✗ $208,125 is the tax calculated using the 2026 current LCGE limit of $1,275,000 (($2,200,000 – $1,275,000) x 50% x 45% = $208,125), rather than the exam standard figure required by the question.

b. ✓ Correct. Calculated using the 2022 exam standard lifetime capital gains exemption (LCGE) figure of $913,630: deducting the exemption leaves $2,200,000 – $913,630 = $1,286,370; applying the 50% inclusion rate yields a taxable capital gain of $643,185; multiplying by the 45% marginal tax rate results in $289,433 of tax payable. (Note: Under 2026 current rules, the indexed LCGE limit is $1,275,000, which would result in tax payable of $208,125.)

c. ✗ Omits the 50% capital gains inclusion rate, erroneously applying the 45% marginal tax rate directly to the entire remaining gain after the exemption.

d. ✗ $1,000,000 represents the exam standard limit for qualified farm and fishing property, rather than the $913,630 exam–standard limit for qualified CCPC shares.

51′ answer a

a. ✓ Correct. Eligibility for the lifetime capital gains exemption (LCGE) cannot be judged solely by corporate or partnership labels: ordinary commercial partnership interests are ineligible, but qualifying family farm or fishing partnerships under ITA s.110.6 may qualify; meanwhile, registered CCPC status alone does not guarantee that shares meet the qualified small business corporation (QSBC) asset tests.

b. ✗ Falls into the trap of relying solely on the corporate label. Status as a CCPC does not automatically make shares qualified small business corporation (QSBC) shares without verifying statutory active asset tests.

c. ✗ Ordinary commercial partnership interests (such as a retail clothing partnership) do not qualify for the LCGE; only qualifying family farm or fishing partnerships represent an eligible exception.

d. ✗ The LCGE requires strict adherence to statutory QSBC share or qualified farm/fishing property definitions, and does not apply universally to all privately held business interests.

52 answer c

a. ✗ Falls into the 'assuming identical ownership percentages mean identical mechanisms and tax results' trap. Although Sonia ends up owning 100% of the equity under both structures, the purchasing party differs (shareholder personally vs. corporation cancelling shares), resulting in fundamentally different ACB positions.

b. ✗ Under the share redemption method, the corporation buys back and cancels the deceased shareholder's shares, reducing the total share count, and the surviving shareholder receives no cost basis step–up.

c. ✓ Correct. Under the cross–purchase structure, Sonia personally uses the tax–free death benefit to purchase Tariq's shares for $600,000, keeping total shares constant and adding the purchase price to her cost basis ($50,000 + $600,000 = $650,000 total ACB). Under corporate share redemption, the company buys and cancels the shares, leaving Sonia's ACB at her original $50,000.

d. ✗ Under a cross–purchase agreement, premiums paid by shareholders on each other's policies are personal non–business expenditures and cannot be deducted against personal income.

52′ answer b

a. ✗ Life insurance death benefits are paid legitimately upon the insured's death, and cancelling redeemed shares is standard corporate procedure under share redemption; proceeds do not need to be returned to the insurer.

b. ✓ Correct. The primary tax disadvantage of corporate share redemption relative to cross–purchase is that the surviving shareholder did not personally purchase the shares, receiving no step–up in ACB; with her original ACB unchanged, her future taxable capital gain upon selling the company will be substantially larger.

c. ✗ When the corporation redeems and cancels the deceased shareholder's shares, total shares outstanding decrease, leaving Claire owning 100% of the remaining voting shares.

d. ✗ The life insurance death benefit received by the corporation as beneficiary enters the company completely tax–free rather than as taxable active business income.

53 answer d

a. ✗ A pure corporate redemption needs only 4 policies (one per shareholder), but because the corporation pays cash to cancel the shares, the surviving shareholders receive no cost basis step–up.

b. ✗ A criss–cross (cross–purchase) plan with 4 shareholders insuring each other requires 4 x 3 = 12 policies, not 4.

c. ✗ A split–dollar arrangement is a benefit under which a business and a key employee share different rights in one policy; it is not the standard structure for giving shareholders a cost basis step–up under a buy–sell agreement.

d. ✓ Correct. The hybrid method (promissory note method) allows the corporation to own just 4 policies (one on each shareholder); the surviving shareholders purchase the deceased shareholder's shares by issuing promissory notes to obtain a cost basis step–up, the corporation receives the tax–free death benefit to credit its CDA and pays a tax–free capital dividend, and the survivors use those funds to retire the notes.

53′ answer b

a. ✗ Wrong: the policy counts are reversed. Three partners insuring each other need 6 policies, while corporate ownership needs only 3.

b. ✓ Correct. Under a cross–purchase agreement with three partners, each partner must own a policy on the other two, requiring 3 x 2 = 6 separate policies. Under corporate ownership, the company owns just one policy on each partner, requiring only 3 policies in total.

c. ✗ Cross–purchase mandates that each owner hold independent coverage on every other owner; adding contingent beneficiaries cannot resolve three–way cross–purchase obligations.

d. ✗ Cross–purchase among three partners requires 6 policies (3 x 2), not 9, while corporate ownership typically requires one policy per partner (3 policies total).

54 answer b

a. ✗ Falls into the 'crediting the full tax–free death benefit to the CDA' trap. While the entire $1,500,000 enters the corporation tax–free, the portion equal to the policy's $220,000 adjusted cost basis (ACB) cannot credit the capital dividend account (CDA).

b. ✓ Correct. The corporation receives the $1,500,000 life insurance death benefit entirely tax–free. However, only the excess over the policy's adjusted cost basis ($1,500,000 – $220,000 = $1,280,000) credits the capital dividend account (CDA) for tax–free distribution to shareholders.

c. ✗ The $220,000 portion equal to ACB is received by the corporation tax–free as well; it simply cannot credit the CDA, but does not trigger immediate corporate income tax upon receipt.

d. ✗ Death benefits from an exempt life insurance policy are not capital gains and are not subject to a 50% inclusion rate; the full $1,280,000 excess over ACB credits the CDA at 100%.

54′ answer a

a. ✓ Correct. Although term insurance rarely develops cash surrender value (CSV), it can still carry a non–zero adjusted cost basis (ACB); for both term and permanent coverage, the CDA credit is strictly limited to the death benefit minus actual ACB, so lacking a CSV never guarantees a 100% CDA credit.

b. ✗ Erroneously assumes that having no CSV guarantees an ACB of zero. Term insurance can generate a positive ACB in years where cumulative premiums exceed cumulative NCPI.

c. ✗ Corporate–owned term life insurance death benefits are fully eligible for the CDA mechanism, and the excess over actual ACB credits the CDA normally.

d. ✗ Corporate–paid life insurance premiums funding a buy–sell agreement cannot be deducted as operating expenses, nor does term coverage automatically guarantee a 100% CDA credit.

55 answer c

a. ✗ Although a business has an insurable interest in a key employee, the face amount cannot be set arbitrarily high; it must reasonably correspond to the actual financial loss the firm would suffer.

b. ✗ The exam standard contains no statutory formula mandating a simple mathematical average, and underwriters will invariably require supporting financial statements.

c. ✓ Correct. The three valuation methods (income multiple, profit contribution, and replacement/debt protection) cross–reference one another. The agent must explain the underlying losses and timeframes, selecting a financially justified amount; underwriters require financial verification and will decline or reduce coverage that vastly exceeds realistic economic loss.

d. ✗ A split–dollar arrangement is an executive benefit mechanism dividing policy rights between employer and employee; it cannot be used to bypass financial underwriting scrutiny.

55′ answer b

a. ✗ Summing headhunter fees, training costs, and tied loan balances represents the replacement and debt protection method, not the profit contribution method; furthermore, key person policies are owned by the business.

b. ✓ Correct. Summing recruiter headhunting fees, training overlap salary costs, and personally guaranteed demand loan balances represents the replacement and debt protection method. Key person life insurance is owned by and payable to the corporation, providing tax–free proceeds to absorb these specific financial shocks.

c. ✗ This is not the income multiple method based on annual salary multiples; furthermore, coverage owned by and payable to a spouse is personal life insurance, not corporate key person insurance.

d. ✗ Split–dollar is an executive benefit arrangement rather than a coverage valuation method, and key person insurance is not owned across a group of ordinary employees.

56 answer a

a. ✓ Correct. Under a split–dollar arrangement, the corporation and employee share distinct interests in one permanent policy (death benefit vs. cash value) and split premiums based on fair market value under CRA administrative guidelines. For a qualifying BC CCPC, the small business tax rate on the first $500,000 of active business income is 11% (federal 9% plus BC 2%).

b. ✗ Split–dollar involves sharing rights in a single permanent policy rather than issuing two separate term policies, and premiums must be divided at fair market value to avoid taxable employee benefit issues.

c. ✗ A lower corporate small business tax rate is only one consideration; determining whether corporate ownership saves tax overall requires factoring in personal withdrawal taxes, business limits, ACB tracking, and CDA distribution costs.

d. ✗ The 11% combined small business rate applies strictly to active business income of an eligible CCPC up to the $500,000 business limit, not to unlimited passive investment income.

56′ answer b

a. ✗ If the employee holds 100% of the policy rights while the company pays the entire premium, the arrangement constitutes a taxable employee benefit rather than a bona fide split-dollar arrangement.

b. ✓ Correct. The core mechanism of a split-dollar arrangement is that the corporation and key employee share distinct rights in a single permanent policy (such as dividing face amount and cash surrender value) and split the premium payments according to the fair market value of their respective interests.

c. ✗ The capital dividend account (CDA) is a corporate tax account belonging exclusively to private corporations; an individual employee has no personal CDA.

d. ✗ The Income Tax Act contains no statutory provision establishing a rigid 50/50 split; under CRA administrative policy, premiums must be allocated based on the fair market value of the respective interests.

Chapter 9 answers and reasons

57 answer b

a. ✗ Incorrect. Classic trap: confusing standard rate classification with premium ratings. Smoker status determines that the applicant falls under the independent smoker standard rate classification; it does not mean the policy itself is a rated policy.

b. ✓ Correct. Frequent participation in a hazardous avocation (such as backcountry skiing, paragliding, or motor racing) falls outside the standard rate classification framework and represents additional mortality risk, leading to a rated policy or a specific exclusion clause.

c. ✗ Incorrect. As long as it does not constitute alcohol abuse or accompany other health issues, occasional social drinking is treated as a standard risk and will not trigger a rating on its own.

d. ✗ Incorrect. A high school teacher is a low-risk standard occupation that does not trigger an occupational rating; age merely determines which standard rate table applies.

57′ answer d

a. ✗ Incorrect. Smoker status directly corresponds to an independent smoker standard rate table, rather than an extra rating superimposed on standard rates.

b. ✗ Incorrect. Occasional social drinking at family dinners does not constitute alcohol abuse and will not trigger a rated policy.

c. ✗ Incorrect. Age affects pricing on the standard rate tables; a healthy 50-year-old non-smoker still qualifies for standard rates rather than a rated category.

d. ✓ Correct. A Motor Vehicle Record (MVR) reflects 3 to 10 years of driving history; multiple serious driving convictions exceed the standard rate framework and lead to a rated policy.

58 answer a

a. ✓ Correct. A Temporary Insurance Agreement (TIA / conditional receipt) requires completing a separate health questionnaire; answering 'yes' to any question automatically disqualifies the applicant from receiving a TIA, even if the initial premium has been paid.

b. ✗ Incorrect. Classic trap: treating submitting a complete application and paying at least one month of premium as sufficient conditions for a TIA, ignoring the strict requirement that all TIA health questions must be answered 'no'.

c. ✗ Incorrect. There is no rule in a TIA granting half coverage when answering 'yes'; answering 'yes' to any health question automatically prevents temporary coverage from being issued.

d. ✗ Incorrect. An agent's discretion permits refusing to issue a TIA when having doubts; the agent has no authority to override a 'yes' answer on TIA health questions and issue temporary coverage.

58′ answer c

a. ✗ Incorrect. An agent should issue a TIA only when having no doubts about the applicant's insurability and having received the initial premium; issuing a TIA despite evident severe symptoms is a failure of duty.

b. ✗ Incorrect. An agent has no authority to draft or attach an exclusion clause; that is strictly the responsibility of head office underwriters.

c. ✓ Correct. The agent has genuine discretion when issuing a Temporary Insurance Agreement (TIA): when observing persistent coughing or other evident health concerns, the agent must refuse temporary coverage and truthfully record the observations in the agent's comments for underwriter evaluation.

d. ✗ Incorrect. An agent may refuse to issue temporary coverage under a TIA during underwriting, but deciding whether to accept, postpone, or decline the underlying permanent application rests solely with head office underwriters.

59 answer c

a. ✗ Incorrect. Classic trap: an MIB report can never be used alone to decline coverage; declining directly on this basis skips the mandatory independent verification step.

b. ✗ Incorrect. The MIB stores only coded risk clues; it does not hold full hospital medical records or specific decline or rating decisions made by other insurers.

c. ✓ Correct. A Medical Information Bureau (MIB) report cannot serve as the sole basis for an underwriting decline; the underwriter must independently verify that the condition actually exists through an Attending Physician's Statement (APS) or medical examination before making a decision.

d. ✗ Incorrect. Once the applicant signs the authorization on the application, member insurers legally share coded risk information through the MIB to protect against undisclosed medical history across companies.

59′ answer a

a. ✓ Correct. The MIB shares specific coded medical or risk information (rather than underwriting decline decisions themselves), and underwriters must independently verify the medical facts before declining or rating an application.

b. ✗ Incorrect. The MIB records coded risk facts rather than decline decisions, and a decline by one insurer is not a legal barrier to applying with another insurer.

c. ✗ Incorrect. An MIB report cannot serve as the sole basis for declining an application; an independent verification procedure by the underwriter is mandatory.

d. ✗ Incorrect. The purpose of the MIB is precisely to maintain coded risk information to prevent applicants from concealing medical history across multiple insurers.

60 answer d

a. ✗ Incorrect. Issuing a policy is not the end of underwriting; policy delivery is a continuation of the process, requiring that insurability remains unchanged before the contract takes effect.

b. ✗ Incorrect. The 10-day free-look period protects the policyowner's right to cancel and obtain a full refund; it does not allow an agent to improperly deliver a policy when the insured's insurability has changed.

c. ✗ Incorrect. An agent has no authority to create exclusion clauses, and delivery must not be completed when insurability has materially changed.

d. ✓ Correct. A policy takes effect upon delivery only when the policyowner accepts it, the initial premium is paid in full, and the insured's insurability has not materially changed since the application; if insurability has changed, the agent must not deliver the policy and must contact head office underwriting.

60′ answer b

a. ✗ Incorrect. A policy takes effect once the three delivery conditions are met, without waiting for the 10–day free–look period to expire; additionally, FINTRAC large cash reporting is triggered only upon receiving $10,000 or more in cash.

b. ✓ Correct. Policy delivery takes effect only when three conditions are concurrently met: (1) the delivered policy is accepted by the applicant/policyowner; (2) the initial premium is paid in full; and (3) the insurability of the life insured has not changed between application and delivery.

c. ✗ Incorrect. Delivery only requires confirming that health, occupation, avocations, and financial status have not materially changed; it does not require a new medical examination on delivery day or paying a full annual premium in cash.

d. ✗ Incorrect. Identity verification of named beneficiaries does not necessarily occur at application or delivery, nor does it form one of the three core conditions for policy delivery.

61 answer b

a. ✗ Incorrect. Classic trap: conflating innocent mistakes with fraud. Under BC Insurance Act s. 52, the two–year incontestability period protects only non–fraudulent mistakes; fraudulent misrepresentation can never invoke this two–year protection.

b. ✓ Correct. Intentionally misrepresenting smoking status constitutes fraudulent misrepresentation of a material fact, which is not protected by the two–year incontestability clause; the insurer may void the contract and deny the claim even after two years.

c. ✗ Incorrect. Proportionally adjusting the death benefit is the specific remedy for misstatement of age under BC Insurance Act s. 54, which does not apply to intentional fraudulent misrepresentation of smoking status.

d. ✗ Incorrect. A material fact is defined by whether disclosure would influence the underwriting decision; smoking status directly affects premium rate decisions, so fraudulent concealment gives the insurer the right to void the contract regardless of the cause of death.

61′ answer a

a. ✓ Correct. Under BC Insurance Act s. 52, non–fraudulent innocent mistakes are protected by incontestability once the contract has been in force for two years during the insured's lifetime; misstatement of age is governed separately by s. 54, adjusting coverage or premiums accordingly.

b. ✗ Incorrect. Non–fraudulent innocent mistakes are protected by incontestability once the contract has been in force for two years during the insured's lifetime, preventing the insurer from voiding the policy.

c. ✗ Incorrect. Misstatement of age is governed by specific statutory provisions (s. 54) rather than being frozen by incontestability, requiring an adjustment to coverage based on true age.

d. ✗ Incorrect. As long as the true age is within insurable limits, misstatement of age is resolved by adjusting coverage rather than canceling the contract, and no regulatory fines apply.

62 answer c

a. ✗ Incorrect. Accelerated underwriting is not unconditional acceptance (which resembles guaranteed issue), and simplified issue is specifically designed to bypass medical exams and Attending Physician's Statements.

b. ✗ Incorrect. This completely reverses the facts: accelerated underwriting retains preferred, standard, and rated tiers, whereas simplified issue does not use risk tiers and typically charges higher overall premiums.

c. ✓ Correct. Accelerated underwriting performs full risk assessment using algorithms and existing data (MIB, driving records, credit history) without exams, retaining preferred, standard, and rated tiers; simplified issue uses short questionnaires and instant data to accept or decline without tiering, typically charging higher premiums.

d. ✗ Incorrect. In the exam material, amounts up to $2,000,000 are examples of modern no–medical thresholds rather than statutory limits, and term life is not required to go through simplified issue.

62′ answer d

a. ✗ Incorrect. Accelerated underwriting only waives traditional medical exams; it continues to evaluate all three risk categories using questionnaires and existing data such as MIB, MVR, and credit records.

b. ✗ Incorrect. Accelerated underwriting is an initial issuance process at application and has no connection to the two–year incontestability period.

c. ✗ Incorrect. Accelerated underwriting explicitly preserves risk classification and tiered pricing, including preferred, standard, and rated premiums.

d. ✓ Correct. Although accelerated underwriting skips traditional medical exams, it conducts full underwriting classification using algorithms and data such as MIB and MVR; hazardous avocations or driving convictions can still result in a rated policy.

63 answer a

a. ✓ Correct. Under exam rules, insurable interest is required only at the time of policy issue, so a subsequent divorce does not retroactively invalidate the original policy; however, applying for a new $200,000 policy is a separate transaction that must meet insurable interest (or written consent under BC Insurance Act s. 45(2)(b)) and underwriting criteria anew.

b. ✗ Incorrect. Classic trap: misunderstanding insurable interest as a continuous requirement up to the claim date; because spousal insurable interest existed at issue, a subsequent divorce does not void the existing contract.

c. ✗ Incorrect. Purchasing an additional policy is a brand–new transaction requiring re–evaluation of insurable interest (or written consent), financial justification, and underwriting insurability at the time of the new application.

d. ✗ Incorrect. The existing policy is already fully in force and does not require nor permit annual renewal of a Temporary Insurance Agreement (TIA) to maintain its validity.

63′ answer b

a. ✗ Incorrect. Insurable interest is required only at policy issue; terminating the employment relationship does not cause an existing policy to become void.

b. ✓ Correct. Insurable interest is required only at the time of policy issue; subsequent changes in employment or marital relationships do not have retroactive effect, and the contract remains valid and in force.

c. ✗ Incorrect. Policy ownership does not automatically transfer when an employee resigns, nor does the contract convert into a simplified issue policy.

d. ✗ Incorrect. The employee retiring after six years does not constitute misrepresentation at application, nor does it grant the insurer the right to void the policy.

Chapter 10 answers and reasons

64 answer b

a. ✗ Incorrect. Falls into the trap of omitting deduction of available existing coverage: adding the 10–year capitalized income shortfall of $275,000 to the mortgage balance of $410,000 and funeral expenses of $15,000 yields total capital needs of $700,000, but treats total capital needs directly as the final recommended coverage, forgetting to deduct the $100,000 of existing group life insurance.

b. ✓ Correct. Under the capital needs approach, first add the capitalized income shortfall of $275,000 to the one–time capital needs ($410,000 mortgage balance + $15,000 funeral expenses = $425,000) to find total capital needs of $700,000, then subtract the $100,000 of available existing group life insurance to arrive at the capital shortfall, which is the recommended new coverage of $600,000.

c. ✗ Incorrect. Calculates only the one–time capital needs ($410,000 mortgage balance + $15,000 funeral expenses = $425,000), omitting both the $275,000 10–year capitalized income shortfall and the deduction for $100,000 of existing group life insurance.

d. ✗ Incorrect. Falls into the trap of using property market value instead of mortgage balance: uses the property's $860,000 market value directly as the coverage need, ignoring that mortgage repayment only requires clearing the $410,000 mortgage balance, and fails to incorporate the income shortfall or deduct existing coverage under the capital needs approach.

64′ answer d

a. ✗ Incorrect. Falls into the traps of omitting existing coverage and missing one–time capital needs: $519,000 is merely the 14–year capitalized income shortfall, which neither adds the $20,000 funeral costs and $8,000 credit card debt nor subtracts the $150,000 employer group life insurance.

b. ✗ Incorrect. Confuses existing coverage with recommended new coverage: $150,000 is Maya's current employer group life insurance amount, which should be subtracted from total capital needs as a deduction rather than recommended as new coverage to purchase.

c. ✗ Incorrect. Falls into the trap of confusing capital retention with capital drawdown: mistakenly applies the capital retention method (which preserves principal indefinitely) to a 14–year child dependency need to get $2,155,000, and fails to factor in one–time capital needs or the deduction for existing group insurance.

d. ✓ Correct. Under the capital needs approach, add the 14–year capitalized income shortfall of $519,000 to the one–time capital needs ($20,000 funeral + $8,000 credit card = $28,000) to get $547,000, then subtract the $150,000 existing group life insurance to arrive at the capital shortfall, which is the recommended new coverage of approximately $397,000.

65 answer c

a. ✗ Incorrect. Skips calculation steps by making no tax or inflation adjustments: directly calculates $84,000 / 5% = $1,680,000, failing to deduct the 25% marginal tax rate on investment income or adjust for 2% inflation erosion.

b. ✗ Incorrect. Makes only the after–tax return adjustment: calculates an after–tax rate of return of 5% x (1 – 25%) = 3.75% and divides $84,000 / 3.75% = $2,240,000, omitting the subsequent 2% inflation adjustment step.

c. ✓ Correct. Under the income replacement approach, adjust sequentially: first determine the after–tax rate of return = 5% x (1 – 25%) = 3.75%, then calculate the after–tax, inflation–adjusted rate of return = (1 + 3.75%) / (1 + 2%) – 1 ≈ 1.72%, and dividing with full precision gives $84,000 / [(1.0375 / 1.02) – 1] = $4,896,000.

d. ✗ Incorrect. Adjusts only for inflation while omitting tax adjustments: calculates only the inflation–adjusted rate of return [(1 + 5%) / (1 + 2%) – 1] ≈ 2.94% and divides $84,000 / [(1.05 / 1.02) – 1] = $2,856,000, ignoring the 25% marginal tax rate.

65′ answer a

a. ✓ Correct. When accounting for the after-tax rate of return only, the denominator is 5% x (1 – 25%) = 3.75%, resulting in a capitalized value of $84,000 / 3.75% = $2,240,000.

b. ✗ Incorrect. Fails to account for income taxes: $1,680,000 is the unadjusted capitalized value calculated directly using the nominal 5% rate of return ($84,000 / 5%).

c. ✗ Incorrect. Confuses the inflation-only adjustment with the tax-only adjustment: $2,856,000 is the result of adjusting solely for 2% inflation without deducting the 25% tax rate.

d. ✗ Incorrect. Adds an unnecessary inflation adjustment: $4,896,000 is the result of dual adjustments for both the 25% tax rate and 2% inflation, rather than the single after-tax return step.

66 answer a

a. ✓ Correct. The capital drawdown method assumes spending down both principal and interest over a specified duration, making it best suited for needs with a definite end point (such as covering a 14-year child dependency period or fixed-term support); mistakenly using the capital retention method for temporary needs overestimates required coverage by more than fourfold.

b. ✗ Incorrect. Confuses the definitions of the two methods: preserving all principal indefinitely and living solely off investment returns is the core premise of the capital retention method, not the capital drawdown method.

c. ✗ Incorrect. Confuses the income replacement approach with capital drawdown: using a quick ballpark estimate during an initial interview without probing survivor expenses or duration describes the income replacement approach, whereas capital drawdown is a method within the capital needs approach for finite time horizons.

d. ✗ Incorrect. Reverses the appropriate scenario: lifelong spousal income replacement without a definite end point calls for the capital retention method; applying a 14-year drawdown method to a permanent need would exhaust funds after 14 years.

66′ answer c

a. ✗ Incorrect. Reverses the characteristics of the two methods: requiring detailed post-death household financial data and taking longer to calculate describes the capital needs approach, whereas the income replacement approach is fast and suited for initial rough estimates.

b. ✗ Incorrect. Contradicts the core formula of the capital needs approach: the capital needs approach must deduct assets available upon death and existing coverage; it is the income replacement approach (assuming perpetual principal retention) that tends to calculate unnecessarily large coverage.

c. ✓ Correct. The capital needs approach itemizes actual post-death income shortfalls, duration, and one-time capital needs, and subtracts available assets and existing coverage to accurately reflect the family's true shortfall, which is why exam materials explicitly recommend it.

d. ✗ Incorrect. Fabricates a statutory mandate: the capital needs approach is an industry-recommended professional financial analysis method, not a statutory formula mandated by BC's Family Law Act for all married couples.

67 answer d

a. ✗ Incorrect. Blindly accepts client assumptions and omits an obligation: silence regarding insurance in an agreement does not mean the support obligation automatically terminates upon death; failing to examine agreement wording and omitting the $900 monthly payment through age 19 leaves the estate exposed to support claims.
b. ✗ Incorrect. Misinterprets BC's Family Law Act: s. 170(e) allows a court to order a payor who already owns life insurance to designate a spouse or child and maintain premiums, which cannot be rewritten as an automatic order to purchase a new policy.
c. ✗ Incorrect. Confuses government benefits with family law obligations: the CPP children's benefit does not legally extinguish support obligations under a mediation agreement, nor does it prevent a former spouse from claiming against the estate if the agreement lacks explicit termination language.
d. ✓ Correct. When addressing court–ordered insurance and related support liabilities, mediation agreements must be evaluated under their precise wording and BC Family Law Act s. 171; if the agreement is silent on termination upon death, the former spouse may still claim against the estate, so the agent must examine the agreement text.

67′ answer b

a. ✗ Incorrect. Confuses mediation agreements with court orders: mediation agreements and court orders are distinct legal instruments; while a dependent can apply to court when an agreement is silent, it does not automatically grant the entire estate.
b. ✓ Correct. In BC, Family Law Act s. 170(e) can require a payor with existing insurance to designate a spouse or child as beneficiary and maintain premiums; under s. 171, if an agreement does not explicitly state that support terminates upon death, the former spouse may still claim against the estate.
c. ✗ Incorrect. Mistakenly assumes that omitting insurance voids the obligation: even if an agreement contains no explicit insurance clause, as long as the support obligation lacks clear wording terminating upon death, the former spouse can still claim against the estate.
d. ✗ Incorrect. Contradicts legal realities: to secure ongoing spousal or child support payments after death, a former spouse or child from a prior marriage is commonly designated as beneficiary, and remarriage does not make such designations unlawful.

68 answer a

a. ✓ Correct. Under exam benchmarks, both trigger deemed disposition at death; Nora's qualified small business corporation shares can utilize the lifetime capital gains exemption (LCGE) up to the 2022 exam limit of $913,630, whereas Leo's general operating partnership interest does not qualify for the LCGE. Note that while the exam uses the 2022 limit of $913,630, the 2026 current CRA limit is indexed to $1,275,000 (and qualified family farm or fishing partnerships may qualify if eligible).
b. ✗ Incorrect. Fabricates a tax–free rollover to siblings: capital property at death is generally deemed disposed of at fair market value under Income Tax Act s. 70(5), and no automatic tax–free rollover exists for transfers to siblings.
c. ✗ Incorrect. Reverses the tax treatment of corporate shares and general partnerships: CCPC shares meeting QSBC definitions qualify for the lifetime capital gains exemption (LCGE), whereas general operating partnership interests trigger capital gains that do not qualify for the LCGE.
d. ✗ Incorrect. Misapplies the dual–benchmark trap: general operating partnership interests are not eligible for the LCGE, and even if an individual holds both QSBC shares and qualified farm property, they share a single lifetime LCGE limit rather than two separate full exemptions.

68′ answer d

a. ✗ Incorrect. Mistakes an exemption deduction for complete non–recognition: deemed disposition of shares at death first produces a $640,000 capital gain and a 50% taxable capital gain of $320,000, which the capital gains deduction offsets against regular tax; however, alternative minimum tax (AMT) must still be reviewed.
b. ✗ Incorrect. Confuses CCPC shares with general operating partnerships: CCPC shares meeting QSBC criteria can utilize the lifetime capital gains exemption (LCGE) and cannot be conflated with ineligible general operating partnerships.
c. ✗ Incorrect. Confuses cost base with the capital gains formula: capital gain on deemed disposition equals fair market value ($650,000) minus ACB ($10,000), which is $640,000; tax is not levied on the ACB nor taxed as a corporate dividend.
d. ✓ Correct. Shares are deemed disposed of at fair market value at death, producing a capital gain of $650,000 – $10,000 = $640,000, of which 50% ($320,000) is a taxable capital gain; this can be offset against regular income tax by the capital gains deduction within the 2026 LCGE limit of $1,275,000, subject to alternative minimum tax (AMT).

69 answer b

a. ✗ Incorrect. Falls into the trap of mixing illiquid assets into the available asset pool: treats the total book value of $1,180,000 directly as assets available upon death, overlooking that the home where the spouse continues living and corporate shares the family retains to operate will not be liquidated for cash.
b. ✓ Correct. Assets available upon death include only assets that the family is genuinely willing to liquidate for estate needs; the family home where the spouse will continue residing and the $650,000 in corporate shares retained to operate must be excluded from the liquid pool, making available assets far lower than the $1,180,000 book value.
c. ✗ Incorrect. Confuses capital gains with liquid cash: the $640,000 gain (market value $650,000 minus ACB $10,000) is used to calculate deemed disposition tax liabilities; paper capital gains can never be treated as liquid cash.
d. ✗ Incorrect. Violates the family's intention to retain business operations: as long as the family plans to keep the corporation operating rather than sell it, the entire $650,000 share value cannot be included in assets available upon death.

69′ answer a

a. ✓ Correct. Assets available upon death must strictly distinguish total assets from assets genuinely available for estate needs: family property passed to children and retirement accounts retained by the spouse are excluded from liquid assets regardless of book value; only the savings account truly available to clear debt may be deducted.
b. ✗ Incorrect. Falls into the trap of mixing illiquid assets into the available asset pool: mistakenly pools the retained cottage and spousal retirement account into available assets, and fails to realize that even liquidated assets must be net of debt, taxes, and transaction costs rather than gross market value.
c. ✗ Incorrect. Completely reverses the asset availability rules: liquid cash readily available to settle debts is precisely what constitutes assets available upon death, whereas retained properties and ongoing retirement accounts must be excluded.
d. ✗ Incorrect. Omits a vital component of the formula: the proper formula under the capital needs approach is recommended coverage = total capital needs – assets available upon death – existing coverage; both available assets and existing coverage are subtracted.

70 answer c

a. ✗ Incorrect. Misapplies the dual–benchmark trap: even the $2,500 top–up introduced in 2025 requires that the deceased never received CPP/QPP retirement or disability benefits and leaves no surviving spouse or common–law partner eligible for a survivor's pension; Owen is married with an eligible survivor, so he does not qualify for $5,000, nor can maximum monthly benefits be applied unconditionally to everyone.

b. ✗ Incorrect. Violates coverage review principles: CPP survivor benefits must be formally applied for rather than paid automatically, and estimated approved benefits represent post–death income and existing coverage that must be included in the needs analysis.

c. ✓ Correct. Exam answers follow exam benchmarks: the basic CPP lump–sum death benefit is $2,500, monthly survivor and child benefits follow the figures stated in the question stem or exam snapshot, and needs analysis uses estimated approved amounts rather than assuming the maximum ceiling. Note that while the exam uses 2022 snapshot figures ($674.79 for survivors under 65, $264.53 for children), 2026 maximums are $803.54 and $307.81, and starting in 2025 death benefits can reach up to $5,000 where there is no eligible survivor.

d. ✗ Incorrect. Confuses workers' compensation scope: WorkSafeBC's funeral benefit maximum of $11,704.51 is a workers' compensation fatality benefit payable only for work–related injuries or occupational diseases, and cannot substitute for CPP death benefits in non–occupational illness deaths.

70′ answer b

a. ✗ Incorrect. Mismatches statutes and timeframes: 90 days is the statutory window under BC's Pension Benefits Standards Act (PBSA) s. 80 for a spouse to sign a joint–and–survivor pension waiver; BC has no statutory enactment mandating a 90–day group life conversion period.

b. ✓ Correct. Under existing coverage review dual–benchmark rules, the exam text contains internally inconsistent references to both a 30–day and a 31–day group life conversion window (candidates follow the question stem), whereas in BC conversion privileges rest on CLHIA industry self–regulatory guidelines rather than statutory enactment.

c. ✗ Incorrect. Fabricates employer–funded continuation: group life insurance typically terminates upon leaving employment; temporary coverage that disappears upon resignation is never continued free of charge for 14 years by an employer, nor should it offset permanent needs.

d. ✗ Incorrect. Contradicts group conversion fundamentals: exercising conversion privileges within the specified window (30 or 31 days under exam materials) generally requires no new evidence of insurability, and there is no rule requiring full medical underwriting within 60 days or barring conversion before age 65.

Chapter 11 answers and reasons

71 answer a

a. ✓ Correct. Based on bringing it all together and the product selection decision tree, when a client has a clear term need with a fixed horizon (such as a twenty-year mortgage and child dependency period), long-term estate needs are still uncertain, and current income is limited, convertible term insurance is the preferred recommendation, preserving the option to convert to permanent coverage when future income becomes more certain.

b. ✗ Falls into the 'misplaced objective' trap. It is an error to treat whole life insurance with the highest face amount and most expensive premiums as the 'safest' default recommendation; for a client with tight cash flow, expensive permanent insurance may lead to an inability to maintain premium payments and cause a policy lapse, violating product suitability.

c. ✗ Misunderstands the premium payment mechanism of universal life insurance. Flexible premium payments do not mean a client can stop paying for years; the client's ability to consistently cover the cost of insurance (COI) must be tested, making it unsuitable for a client with limited current income who solely needs low-cost term protection.

d. ✗ Falls into the 'product mismatch' trap. A joint last-to-die policy pays only upon the death of the second insured person, designed for tax liabilities deferred until the second spouse dies, and completely fails to provide the immediate funds needed for the mortgage and child living expenses upon Elena's death.

71′ answer c

a. ✗ Overlooks the duration of risk. Estate capital gains tax is a permanent, definite obligation; once term insurance expires, if the insured is still living, coverage ceases or subjects the clients to prohibitive renewal premiums.

b. ✗ Errs by using short-term coverage to address an estate tax liability triggered only upon death, which violates the principle of matching policy type to risk duration and results in exorbitant renewal costs at advanced ages.

c. ✓ Correct. According to the six-step recommendation process and product selection decision tree, when assets can roll over between spouses, taxes are deferred until the death of the second spouse, the need is lifelong, and the clients have maxed out their RRSP and TFSA room, a joint last-to-die permanent life insurance policy should be recommended.

d. ✗ Misunderstands the characteristics of group life insurance. Group coverage typically has maximum benefit limits, terminates upon job termination or retirement, or is subject to restrictive conversion rules, making it unsuitable for funding permanent estate tax liabilities.

72 answer b

a. ✗ Falls into both the 'missing a step' and 'jurisdictional confusion' traps. Comparing term policies of different durations cannot rely solely on first-year premiums while ignoring the renewal jump after ten years; furthermore, outside Quebec (such as in BC), naming a married spouse as beneficiary is revocable by default.

b. ✓ Correct. In steps three and four of the recommendation process, the agent must perform a cumulative cost analysis comparing total premiums over the full twenty years (taking into account the ten-year term renewal jump); furthermore, across Canada outside Quebec, all beneficiary designations are revocable by default, so even when naming a spouse, changes do not require spousal consent unless explicitly declared irrevocable.

c. ✗ Reverses probate implications and overlooks renewal costs. Naming the estate as beneficiary causes the death benefit to fall into the probate process and incur probate fees, whereas naming a designated individual beneficiary bypasses probate.

d. ✗ Violates term pricing mechanics and beneficiary rules. Premiums on a ten-year term policy jump significantly at renewal in year eleven, so cumulative twenty-year premiums generally differ from a twenty-year term policy; additionally, revocability depends on whether an irrevocable declaration was made, not on primary versus contingent beneficiary status.

72′ answer a

a. ✓ Correct. Beneficiary designations across Canada are revocable by default, even when naming a spouse; however, in Quebec (CCQ art. 2449), designating a legally married or civil union spouse in writing outside a will is irrevocable by default, unless explicitly stipulated as revocable.

b. ✗ Falls into the 'jurisdictional confusion' trap by improperly extending Quebec's unique default irrevocable rule for married spouses to BC and all other common-law provinces.

c. ✗ Overlooks Quebec's statutory spousal exception, and naming the estate as beneficiary can always be freely changed by the policyholder and can never automatically become irrevocable.

d. ✗ Completely reverses the rules. BC treats designations as revocable by default; Quebec's default irrevocable rule applies strictly to legally married or civil union spouses and does not extend automatically to common-law partners.

73 answer a

a. ✓ Correct. Under policy illustration rules and CLHIA Guideline G6, life insurance illustrations containing non-guaranteed amounts must clearly separate guaranteed values from non-guaranteed values and show at least two scenarios for the non-guaranteed elements (including a less favourable scenario); the client's signature confirms understanding the nature of the illustration, rather than agreeing that the insurer guarantees projected returns.

b. ✗ Mistakes non-guaranteed illustrations for an insurer guarantee. Non-guaranteed values are hypothetical projections illustrating how the policy functions, and the insurer never guarantees future returns shown in non-guaranteed columns, even after the client signs.

c. ✗ Confuses the structural differences between term and permanent illustrations. Term insurance has no cash value or dividends, displaying only premium and death benefit columns; rather, it is permanent illustrations containing non-guaranteed values that must display at least two scenarios.

d. ✗ Violates the mandatory requirement that non-guaranteed illustrations must show at least two scenarios. An illustration lacking a less favourable scenario is non-compliant on its face.

73′ answer d

a. ✗ Erroneously assumes universal life illustrations are exempt from the two-scenario rule. Any life insurance illustration containing non-guaranteed values must adhere to the standard of presenting at least two scenarios.

b. ✗ Constitutes severe regulatory misconduct by misleading the client. Guaranteed and non-guaranteed values must be clearly separated, and non-guaranteed projections must never be misrepresented or implied as guaranteed returns.

c. ✗ Inappropriately mixes illustration data across different product types. Universal life depends on credited interest mechanisms and underlying charges of chosen accounts, and participating whole life dividend histories cannot be used as an illustration scenario for universal life.

d. ✓ Correct. Under illustration standards, life insurance illustrations containing non-guaranteed values must display at least two scenarios; if the draft illustration lacks a less favourable scenario, it is non-compliant, and the agent must contact the insurer to obtain a compliant version rather than presenting it to the client.

74 answer b

a. ✗ Falls into both the 'similar terms with different rules' and 'inverted process' traps. Inducing a replacement across different insurers (Alpha to Beta) constitutes twisting rather than internal churning; additionally, an existing policy must never be cancelled before the new policy is in force.

b. ✓ Correct. Using misleading or false representations to persuade a client to replace coverage across different insurers constitutes twisting (or churning if within the same insurer), violating fiduciary duty; furthermore, replacement rules require confirming the new policy is in force and accepted by the client before cancelling the old policy, preventing a coverage gap.

c. ✗ Mistakenly believes the incontestability period transfers between policies. Upon replacing a contract, a new two-year incontestability period restarts on the new policy, and time accrued under the old policy does not carry over.

d. ✗ Inverts the disclosure timing and mistakenly assumes client signatures legalize fraudulent inducement. The Life Insurance Replacement Declaration (LIRD) must be explained and signed before proceeding with a new application, and disclosure documents can never validate deceptive twisting.

74′ answer d

a. ✗ Falls into the 'similar terms with different rules' trap. Twisting applies strictly to misleading replacements between different insurers, whereas this transaction takes place entirely within the same insurer (Omega).

b. ✗ Errs by disguising improper replacement conduct that breaches fiduciary duty as a standard cost comparison procedure.

c. ✗ Confuses terminology. The right of rescission is the client's statutory cooling-off right to withdraw an application (such as within twenty days of signing the replacement declaration in BC), not an agent's improper replacement practice.

d. ✓ Correct. Using misleading or deceptive information to convince a client to replace a policy or withdraw cash value to buy a new policy within the same insurer is specifically defined as churning; across different insurers, it is twisting; both severely violate the agent's fiduciary duty.

75 answer c

a. ✗ Falls into the 'missing a step' trap by blindly applying the rule of thumb that a new policy is always cheaper than renewing, overlooking that Victor started smoking and experienced deteriorating health.

b. ✗ Reverses the rules governing contract renewal versus applying for new coverage. Contractual renewal does not require medical re-underwriting and does not reclassify health status due to smoking; only applying for a brand-new policy requires underwriting as a smoker and restarts the two-year incontestability period.

c. ✓ Correct. Contractual renewal pricing is based on the insured's original issue health rating, unaffected by subsequent smoking (adjusting solely for age 58); conversely, applying for a new policy requires full underwriting based on current smoking and health status (risking higher rates, ratings, or declination), requiring the agent to compare cumulative costs and explain how renewal locks in the original health rating.

d. ✗ Falls into the 'inverted process' trap. For a client with worsened health, cancelling the existing contract prematurely risks leaving the client completely uninsurable if the new application is declined due to smoking and health impairments.

75′ answer b

a. ✗ Distorts the incontestability period rules. While the old policy has passed its two-year incontestability period, replacing it triggers a brand-new two-year incontestability period on the new policy, allowing the insurer to investigate misrepresentations and contest coverage during the first two years.

b. ✓ Correct. In the written reason-why record, the agent must disclose that a new two-year incontestability period restarts on the new policy, initial acquisition costs restart with cash values rebuilding from zero (forfeiting the benefit of amortized front-end charges), and the new policy and critical illness rider are subject to new underwriting based on current age and health.

c. ✗ Confuses non-guaranteed growth mechanics between participating whole life and universal life. Universal life returns depend on credited interest mechanisms and underlying fees of chosen accounts, and participating dividend track records cannot project universal life performance.

d. ✗ Erroneously assumes that adding an ancillary rider waives policy replacement disclosure. Surrendering an existing life insurance contract to purchase a new life insurance policy triggers full replacement disclosure obligations regardless of added riders.

76 answer c

a. ✗ Falls into the 'misapplied premise' trap. Regardless of who initiates the replacement, the agent's disclosure duty applies whenever a transaction constitutes a policy replacement; it protects client consumer rights and does not depend on who originated the idea.

b. ✗ Omits the signature requirement of the life insured. Before proceeding with a replacement application, the agent must explain the declaration and obtain signatures from the applicant; if the life insured is a different person from the applicant, the life insured must sign as well.

c. ✓ Correct. Disclosure is mandatory regardless of who initiates the replacement; under the exam standard, most jurisdictions require the Life Insurance Replacement Declaration (LIRD), whereas Quebec mandates its own Notice of Replacement of Insurance Contract. Note that while the exam standard broadly refers to most jurisdictions requiring the LIRD, in BC section 3(4) of the Insurance Contract (Life Insurance Replacement) Regulation provides the explicit statutory requirement to present the statement and obtain signatures.

d. ✗ Falls into the 'jurisdictional confusion' trap by reversing the territorial scope of the LIRD and Quebec's form. Except for Quebec which uses its own form, other provinces use the standardized LIRD.

76′ answer a

a. ✓ Correct. Under statutory replacement disclosure requirements, before proceeding with a replacement application, the agent must explain the replacement declaration (LIRD) and obtain signatures from the applicant, and also from the life insured when different from the applicant, while attaching a written explanation detailing the reasons for replacement, advantages of the new policy, and circumstances where the new policy might not pay (such as the new two-year incontestability period). Note: while the exam standard broadly states most jurisdictions require the LIRD, in BC this duty is explicitly codified in section 3(4) of the Insurance Contract (Life Insurance Replacement) Regulation.

b. ✗ Errs by substituting verbal confirmation for advance written disclosure, and confuses policy grace periods (30 or 31 days) with pre-application disclosure timing. The replacement declaration must be explained and signed before proceeding with the new application.

c. ✗ Omits the applicant's signature and improperly waives the written explanation. Both the applicant and the life insured must sign when they are different parties, and a written comparison is mandatory regardless of coverage amounts.

d. ✗ Falls into the 'jurisdictional confusion' trap. Aside from Quebec which uses its own form, other provinces including BC mandate the LIRD, backed in BC by explicit provincial statutory regulation.

77 answer d

a. ✗ Violates professional conduct boundaries when a client declines coverage. An agent must never pressure a client who has expressed clear preferences into purchasing larger coverage, which may constitute improper sales practices.

b. ✗ Abandons required record-keeping. If an agent fails to record or discards notes regarding the original recommendation, the agent will have no evidence years later to prove that coverage gaps were fully explained if surviving family members dispute inadequate coverage.

c. ✗ Confuses replacement disclosure with reason-why record requirements. Replacement disclosure applies specifically when replacing an existing contract, whereas a reason-why record should be created for every substantive recommendation, regardless of whether prior policies exist.

d. ✓ Correct. A sound reason-why record contains four core components: client situation summary, alternatives considered and trade-offs, final recommendation matching needs, and client response; when a client purchases only $300,000, the agent must explain the uncovered risk gap, document both the $600,000 proposal and the $300,000 choice, and have the client acknowledge understanding the remaining gap.

77′ answer b

a. ✗ Deviates from the four core elements of a reason-why record. The record documents the agent's professional judgment process and does not require copying the entire policy contract or merely listing commission tables.

b. ✓ Correct. A defensible reason-why record comprises four core elements: 1) a summary of the client's circumstances; 2) alternative options considered and why they were not selected; 3) the final recommendation matched to specific needs; and 4) the client's response (acceptance, partial acceptance, or refusal with documented risk explanation).

c. ✗ Misrepresents non-guaranteed dividends as guaranteed promises, which is not part of a reason-why record and constitutes severe deceptive misconduct.

d. ✗ Confuses a new policy recommendation with a policy replacement. When no prior policy is replaced, a replacement declaration is not required, but maintaining a written reason-why record remains mandatory.

Chapter 12 answers and reasons

78 answer a

a. ✓ Correct. Changing smoking status from smoker to non-smoker directly affects mortality assumptions and premium rate classifications; it is an underwriting change that requires evidence such as a non-smoking declaration or cotinine testing for insurer approval.

b. ✗ Incorrect. A collateral assignment of a policy for a bank loan does not require medical underwriting and is expressly excluded from the definition of a disposition under section 148 of the Income Tax Act, triggering no policy gain tax consequences.

c. ✗ Incorrect. Reducing the face amount decreases the insurer's net amount at risk; it is an administrative change that typically requires no evidence of insurability, provided it meets minimum policy limits and company administrative rules.

d. ✗ Incorrect. Changing a revocable beneficiary by written declaration is an administrative change that does not increase mortality risk and requires no medical underwriting.

78′ answer c

a. ✗ Incorrect. Neither an ownership assignment nor removing a rider increases the insurer's mortality risk, so neither requires medical underwriting.

b. ✗ Incorrect. This inverts the true nature of both actions: removing a rider is a purely administrative change, while permanently transferring policy ownership is an absolute assignment that generally constitutes a taxable disposition.

c. ✓ Correct. Neither removing a rider nor assigning policy ownership requires medical underwriting. However, permanently transferring ownership is an absolute assignment that generally constitutes a disposition under the Income Tax Act, requiring a tax analysis based on the policy's adjusted cost basis (ACB) and rollover rules.

d. ✗ Incorrect. Only a pure collateral assignment is excluded from the definition of a disposition under section 148; an absolute assignment does not qualify for this statutory tax exclusion.

79 answer b

a. ✗ Incorrect. Falls into the 2–year unconditional reinstatement trap. Reinstatement by paying overdue premiums without evidence of insurability is only available during the 30–day post–grace short window; 55 days post–lapse falls outside this window.

b. ✓ Correct. Under BC Insurance Act section 57, when applying for reinstatement after the 30–day post–grace window but within the 2–year long window, the policyowner must pay all overdue premiums and other indebtedness with interest (subject to statutory caps) and provide evidence of good health and insurability satisfactory to the insurer; when all statutory conditions are met, the insurer is obligated to reinstate the policy.

c. ✗ Incorrect. Falls into the dual 30–day continuous coverage trap. The 30–day grace period and the 30–day post–grace reinstatement window cannot be combined into 60 days of continuous coverage; the policy lapses immediately once the grace period expires.

d. ✗ Incorrect. Exceeding 30 days post–grace merely forfeits the short window without underwriting; the policyowner still retains the statutory right to reinstate within 2 years of lapse by submitting evidence of good health.

79′ answer a

a. ✓ Correct. Crucially distinguishes the grace period from reinstatement. Under section 50, a death occurring during the grace period is covered, but once the grace period ends, the policy lapses; section 57 explicitly requires that the life insured be alive when the overdue premium is paid for post–grace reinstatement, making premium tender after death invalid.

b. ✗ Incorrect. Falls into the dual 30–day continuous coverage trap. Deducting the overdue premium from the death benefit applies only when death occurs during the 30–day grace period under section 50, not during the post–grace reinstatement window after lapse.

c. ✗ Incorrect. The life insured is already deceased, failing the fundamental statutory condition that the insured must be alive when payment is tendered; proving prior good health after death does not entitle the beneficiary to reinstatement.

d. ✗ Incorrect. Proportional benefit adjustments apply to age misstatements under section 54, not to claims arising after a policy has lapsed for unpaid premiums.

80 answer c

a. ✗ Incorrect. Under section 60, an irrevocable beneficiary designation cannot be altered or revoked during the beneficiary's lifetime without their consent, nor can it be overridden by a subsequent will.

b. ✗ Incorrect. Under section 66, assigning, surrendering, borrowing against, or otherwise dealing with a contract containing an irrevocable beneficiary designation is subject to the irrevocable beneficiary consent requirements.

c. ✓ Correct. Under BC Insurance Act sections 60 and 66, while an irrevocable beneficiary is living, the policyowner cannot alter or revoke the designation without their consent; dealing with contract rights requires verifying that the beneficiary is at least 19 years of age and obtaining their consent (unless authorized by regulation or court order).

d. ✗ Incorrect. Confuses Quebec's civil code presumption of spousal irrevocability with BC express irrevocable designations; section 60 of the BC Insurance Act explicitly recognizes properly filed irrevocable beneficiary designations.

80′ answer b

a. ✗ Incorrect. Under section 60, an irrevocable beneficiary designation must be filed at the insurer's head or principal office in Canada during the lifetime of the life insured, and the statute expressly prohibits creating irrevocable designations in a will.

b. ✓ Correct. Under BC Insurance Act section 60, an irrevocable beneficiary designation cannot be made in a will; an attempt to do so that is not filed with the insurer during the insured's lifetime operates only as a revocable beneficiary declaration.

c. ✗ Incorrect. A designation that fails to meet statutory irrevocable requirements simply takes effect as a revocable designation; it never voids the insurance policy.

d. ✗ Incorrect. Deficiencies in establishing an irrevocable designation do not cause proceeds to be forfeited to the insurer; the designation is simply administered as a revocable designation.

81 answer b

a. ✗ Incorrect. Falls into the oral or automatic beneficiary change trap. An insurance policy is distinct from a will; outside of Quebec civil code provisions, divorce does not automatically revoke a former spouse's beneficiary designation on an insurance policy.

b. ✓ Correct. Both the exam standard and BC law establish that divorce or remarriage does not automatically alter or revoke a beneficiary designation; unless formally changed via the contract or a signed written declaration, the former spouse on record remains the lawful beneficiary.

c. ✗ Incorrect. Remarriage does not automatically substitute a new spouse as policy beneficiary; any beneficiary change requires a signed written document executed by the policyowner.

d. ✗ Incorrect. Policy lapse is the legal consequence of failing to pay renewal premiums by the end of the grace period; dissolution of marriage does not cause a policy to lapse.

81′ answer d

a. ✗ Incorrect. Under sections 37 and 59, a change of beneficiary must be made by a signed written declaration; oral instructions communicated to an agent do not constitute a valid designation.

b. ✗ Incorrect. Under section 77, until the insurer receives written notice affecting entitlement at its principal office, it is legally entitled to pay the beneficiary on record and obtain a complete discharge.

c. ✗ Incorrect. There is no legal rule requiring an insurer to split proceeds or pay half to a new beneficiary based on unfulfilled oral instructions.

d. ✓ Correct. Under BC Insurance Act sections 59 and 77, altering a beneficiary requires a signed written declaration; paying the former spouse on record before receiving written documentation is legally valid and completely discharges the insurer.

82 answer b

a. ✗ Incorrect. Misleading replacement within the same insurer is churning, whereas misleading replacement across different insurers is twisting; furthermore, an existing policy must never be cancelled before the new policy takes effect.

b. ✓ Correct. Inducing a client to replace a policy across different insurers using misleading information is called twisting. Under BC replacement regulations, a compliant replacement requires presenting and explaining the Life Insurance Replacement Declaration (LIRD) and a written comparison of advantages and disadvantages before taking an application, obtaining signed acknowledgments, and keeping existing coverage in force until the new policy is issued and accepted.

c. ✗ Incorrect. Although improper cross-company replacement is indeed twisting, the LIRD and written comparison must be delivered and signed before taking the new application, not submitted after policy delivery.

d. ✗ Incorrect. Conflates internal churning with external twisting; furthermore, contractual conversions under existing policy rights are not classified as statutory policy replacements.

82′ answer a

a. ✓ Correct. Under BC Insurance Act sections 56 and 57, policy reinstatement reapplies statutory disclosure and incontestability rules to the reinstatement application, and the suicide clause (typically 2 years under the exam standard) begins anew from the most recent reinstatement date.

b. ✗ Incorrect. Reinstatement does not treat the policy as if it never lapsed; the law explicitly resets disclosure verification and the suicide exclusion clock upon reinstatement.

c. ✗ Incorrect. Thirty days refers to the grace period or short reinstatement window; suicide clauses and contestability periods reset to their full contractual or statutory duration (commonly 2 years) upon reinstatement.

d. ✗ Incorrect. The contestability period that restarts upon reinstatement lasts for 2 years while the insured lives, after which unintentional misstatements are once again protected against contestability.

83 answer c

a. ✗ Incorrect. Falls into the age misstatement claim denial trap. Confuses fraudulent misrepresentation with an unintentional age misstatement; an unintentional age error does not void the contract, but triggers a proportional death benefit adjustment.

b. ✗ Incorrect. Under BC Insurance Act sections 52 and 54, age misstatement is explicitly excluded from the 2-year general incontestability protection; the benefit must be adjusted regardless of how long the policy has been in force.

c. ✓ Correct. Under BC Insurance Act section 54, an unintentional misstatement of age adjusts the death benefit proportionally according to the formula: Original Face Amount x Premium Paid / Premium Payable, resulting in $120,000 x ($240 / $300) = $96,000.

d. ✗ Incorrect. Falls into the age misstatement inverted ratio trap. Dividing correct premium by actual premium paid would improperly yield $150,000, rewarding premium underpayment with an increased benefit.

83′ answer b

a. ✗ Incorrect. Course materials note that coverage downward adjustment is not a one-way rule; when age is overstated and excess premiums are paid, section 54 symmetrically increases the death benefit.

b. ✓ Correct. Under BC Insurance Act section 54, the age misstatement formula (Original Face Amount x Premium Paid / Premium Payable) applies symmetrically; when excess premiums were paid, the benefit increases to $120,000 x ($300 / $240) = $150,000.

c. ✗ Incorrect. $96,000 is the downward adjustment resulting from underpaying premiums; when overpaying premiums, the actual $300 paid sits in the numerator and $240 in the denominator, increasing rather than decreasing the payout.

d. ✗ Incorrect. An unintentional age misstatement does not trigger contract rescission or premium refund; it adjusts the proceeds proportionally based on premiums for the true age.

84 answer d

a. ✗ Incorrect. Two years is the incontestability period, the long reinstatement window, or the limitation period following a declaration of presumption of death under section 76, not the exam-standard threshold for disappearance.

b. ✗ Incorrect. Five years is the period under BC section 54 during which an insurer may rescind a contract if the true age exceeds insurable limits while the insured is living, having no relation to presumption of death.

c. ✗ Incorrect. Six years is the absolute long-stop limitation period for life insurance death claims running from the date of death under BC section 76, not the waiting period for disappearance.

d. ✓ Correct. The standard exam answer follows the general exam-standard rule of 7 years of unexplained absence before applying for a declaration of presumption of death; note that under section 3 of BC's Presumption of Death Act, only three conditions (no contact, no reason to believe alive, reasonable grounds of death) are required, with no fixed 7-year statutory waiting period.

84′ answer b

a. ✗ Incorrect. Inverts the statutory order of the simultaneous death presumption; if the insured were presumed to die first, proceeds would flow into the deceased beneficiary's estate, which is precisely what section 83's default rule avoids.

b. ✓ Correct. Under BC Insurance Act section 83 (simultaneous death presumption), when sequence of death is uncertain, the beneficiary is presumed to have predeceased the life insured, so proceeds are distributed as if the beneficiary were not living (passing to the policyowner or their estate); under section 82, faced with competing claimants, the insurer may apply to pay the proceeds into court to secure a full discharge.

c. ✗ Incorrect. Seven years is the exam standard period for presumption of death in missing person cases; a fatal car crash establishes the fact of death immediately without any 7-year wait.

d. ✗ Incorrect. Section 83 does not divide proceeds equally between estates, and section 82 explicitly allows the insurer to apply for payment into court when claims are disputed.

Chapter 13 answers and reasons

85 answer b

a. ✗ Incorrect. Falls into the trap of confusing premature mortality risk with longevity risk. Mortality risk refers to premature death depriving dependents of income, whereas the question stem describes outliving the lifespan that assets can support.

b. ✓ Correct. Longevity risk is defined as outliving accumulated assets and savings, which causes retirement funds to run out before life expectancy (threatening retirement income), while ongoing long-term care costs erode accumulated wealth or pass the financial burden onto the next generation.

c. ✗ Incorrect. Confuses personal longevity risk with business systematic risk. Systematic risk refers to external market risks such as interest rates or economic cycles, which are unrelated to exhausting personal retirement assets by living a very long life.

d. ✗ Incorrect. Confuses short-term disability with retirement longevity risk. Short-term disability risk addresses interruption of employment earnings during working years, not living longer than accumulated savings can support in retirement.

85′ answer c

a. ✗ Incorrect. Falls into the trap of treating longevity as non-existent risk. Longevity is one of the four core risk categories, and a comprehensive needs analysis must address post-retirement longevity and long-term care risks.

b. ✗ Incorrect. Conflates distinct risk concepts. Living a long life is longevity risk rather than mortality risk, and it cannot be solved with accidental death insurance.

c. ✓ Correct. Longevity risk is the only one among the four risk categories that appears positive on the surface, but outliving the lifespan that assets can support exhausts retirement income, and eldercare expenses in later life erode assets intended for the next generation.

d. ✗ Incorrect. Inappropriately applies a short-term government benefit. EI sickness benefits only replace short-term earnings interruption due to illness for qualifying workers; they do not subsidize individuals who exhaust retirement savings in old age.

86 answer a

a. ✓ Correct. Risks threatening business goals fall into two categories: risks tied to the overall market, interest rates, and economic cycles are systematic risks that A&S insurance cannot cover and must be managed operationally; the owner's health impairment preventing payment of fixed overhead is an unsystematic risk (business-specific risk) that A&S business insurance (such as BOE) and self-funding are designed to address.

b. ✗ Incorrect. Mistakenly assumes BOE covers economic downturns. Business Overhead Expense (BOE) insurance reimburses eligible fixed expenses under contract terms only when the owner is disabled from working, and never covers systematic market risks such as rising interest rates or declining customer orders.

c. ✗ Incorrect. Completely inverts the two risk classifications. Industry and interest rate fluctuations are systematic risks, while owner health is an unsystematic risk.

d. ✗ Incorrect. Overlooks the risk transfer function of commercial insurance. The risk of ongoing business fixed overhead during an owner's disability can be transferred to an insurer via BOE coverage, rather than being handled exclusively through risk retention.

86′ answer b

a. ✗ Incorrect. Confuses market competition with a health risk. Market competition and declining demand are operational and market risks, not health or accident events covered by A&S insurance.

b. ✓ Correct. An owner disabled by a car accident is an unsystematic risk that can be covered for eligible fixed overhead through A&S products such as BOE, whereas market competition and economic conditions are systematic risks outside the scope of A&S insurance.

c. ✗ Incorrect. Mistakenly assumes government programs cover business fixed overhead. No government program directly pays commercial office leases or business overhead; business needs must be solved through private insurance or self-funding.

d. ✗ Incorrect. Takes risk avoidance to an unwarranted extreme. Business owners can manage unsystematic health risks by combining self-funding with insurance transfer, without needing to shut down the business to avoid the risk.

87 answer a

a. ✓ Correct. Under the LLQP exam standard, EI sickness benefits pay for a maximum of 15 weeks following a one-week waiting period, replacing 55% of insurable earnings (with a 2022 exam standard cap of $638 per week). Note: while current federal rules extended this to 26 weeks (cap of $729 per week) starting December 18, 2022, candidates answer 15 weeks on the exam based on the exam standard.

b. ✗ Incorrect. Applies workers' compensation replacement percentages to EI. Approximately 90% of net earnings (80% to 90% nationwide under the exam standard) is the benefit percentage for work-related injuries under workers' compensation (WorkSafeBC), not for non-work-related EI sickness benefits.

c. ✗ Incorrect. Fabricates benefit durations and replacement percentages. EI sickness benefits have a one-week waiting period and replace 55% of insurable earnings; neither the exam standard (15 weeks) nor the current rule (26 weeks) provides 52 weeks or 75%.

d. ✗ Incorrect. Confuses short-term EI benefits with long-term CPP-D benefits. Requiring a severe and prolonged disability and paying until age 65 are characteristics of CPP disability benefits (CPP-D), whereas EI sickness is a short-term transitional benefit.

87′ answer c

a. ✗ Incorrect. Reverses the dual-benchmark pairing. Fifteen weeks is the earlier exam standard established in 2022, whereas 26 weeks is the current statutory duration following Bill C-30.

b. ✗ Incorrect. Confuses the four-month CPP-D waiting period with EI duration. Four months is the waiting period after disability onset for CPP-D to begin, not the number of weeks for EI sickness benefits.

c. ✓ Correct. EI sickness benefits replace 55% of insurable earnings under both frameworks, but the maximum benefit duration is 15 weeks (cap of $638 per week) under the exam standard and 26 weeks (cap of $729 per week) under current 2026 rules; candidates answer 15 weeks on the exam and use 26 weeks when mapping real-world client cash flow timelines.

d. ✗ Incorrect. Confuses the self-employed registration waiting period with the benefit duration. Twelve months is the waiting period required after voluntary registration before a self-employed individual can first claim EI special benefits, not the duration of benefit payments.

88 answer c

a. ✗ Incorrect. Falls into the trap of simply adding multiple benefit sources together. Government and group plans are subject to first payor rules, all-source maximum limits, and offset provisions, and can never be stacked in full.

b. ✗ Incorrect. Reverses the first payor order between workers' compensation and EI. The first payor rule looks at the triggering cause: workplace injuries or occupational illnesses are covered first by workers' compensation, and the claimant generally does not collect EI.

c. ✓ Correct. Under the first payor rule, workplace injuries are covered first by workers' compensation (replacing 80% to 90% of net earnings under the exam standard; about 90% in BC under WorkSafeBC), and the claimant generally does not collect EI; secondary group or individual disability plans only fill gaps after statutory caps, and every contract must be reviewed for offset clauses and all-source maximum limits.

d. ✗ Incorrect. Confuses medical expense reimbursement with income replacement. The BC Medical Services Plan (MSP) covers medically necessary physician and hospital services, but provides no wage-loss replacement.

88′ answer a

a. ✓ Correct. When evaluating multiple benefit sources, government benefits, group coverage, and individual policies cannot simply be added together; CPP–D is typically integrated into group disability all–source maximum limits and triggers an offset, and individual policies must also be checked for specific contract terms.

b. ✗ Incorrect. Stacking CPP–D, group LTD, and individual DI ignores all–source maximum limits and offset provisions, grossly overstating the client's actual net monthly income.

c. ✗ Incorrect. Directs a non–work–related illness into a workers' compensation channel. WorkSafeBC covers only work–related injuries and diseases; the applicable government program for non–work–related severe, long–term disability is CPP–D.

d. ✗ Incorrect. Violates proper claims and coordination practices. Claimants should apply for all eligible benefits within statutory timeframes and reconcile them against policy and government rules, rather than forfeiting government benefits to avoid policy coordination rules.

89 answer d

a. ✗ Incorrect. Inverts the classifications of protecting savings and protecting assets. Extended health insurance corresponds to protecting savings against routine bills, while critical illness and long–term care insurance correspond to protecting assets against major or long–term expenses.

b. ✗ Incorrect. Uses an income protection product to solve medical expense and asset preservation needs. Protecting income (DI) replaces employment earnings cash flow, but does not reimburse routine dental or drug bills or serve the asset preservation function of CI or LTC.

c. ✗ Incorrect. Misapplies business insurance and accidental death cover. Priya's concerns are purely personal and family health and asset preservation needs, which do not involve Business Overhead Expense (BOE) or AD&D coverage.

d. ✓ Correct. Among the four A&S need categories, protecting savings prevents accumulated cash savings from being eroded by routine medical, dental, and travel bills outside provincial health care coverage, matching extended health and dental insurance; protecting assets prevents accumulated investment wealth or estate property from being drained by catastrophic illness or prolonged care, matching critical illness (CI) and long–term care (LTC) insurance.

89′ answer b

a. ✗ Incorrect. Recommends disability income insurance to a retiree with no earned income. Liam is retired and has no employment cash flow to replace, making protecting income (DI) inappropriate.

b. ✓ Correct. Preventing catastrophic or prolonged care expenses from forcing the liquidation of accumulated real estate and estate assets falls squarely under protecting assets, addressed by long–term care (LTC) insurance and critical illness (CI) insurance.

c. ✗ Incorrect. Confuses protecting savings with protecting assets. Dental and travel insurance fall under protecting savings, and his retiree plan already covers routine drugs and cleanings; buying duplicate coverage does not address the asset depletion risk of long–term care.

d. ✗ Incorrect. Misapplies a business insurance product to a personal estate planning need. Key person disability insurance falls under protecting business, and is irrelevant to personal retirement asset preservation.

90 answer b

a. ✗ Incorrect. Completely reverses the spectrum from most restrictive to most liberal. CPP total disability (severe and prolonged) has the highest threshold, while own occupation is the most liberal, so this order is inverted.

b. ✓ Correct. The four–level spectrum defining inability to work ranks from most liberal to most restrictive as follows: own occupation –> regular occupation –> any occupation –> CPP total disability; the further along the spectrum, the higher the qualification threshold.

c. ✗ Incorrect. Scrambles the middle and end tiers of the spectrum. Own occupation is more liberal than regular occupation, and CPP total disability is substantially more restrictive than the commercial any occupation definition.

d. ✗ Incorrect. Confuses the relative stringency of commercial disability definitions. In commercial disability policies, any occupation (unable to work in any suitable job) is significantly more restrictive than own occupation (unable to perform the duties of one's specific occupation).

90′ answer d

a. ✗ Incorrect. Selects the most restrictive end of the spectrum. CPP total disability requires a severe and prolonged disability preventing the claimant from regularly pursuing any substantially gainful occupation; because she can work full–time teaching or managing hospital administration, she would not qualify for CPP–D.

b. ✗ Incorrect. Confuses any occupation with own occupation. Under an any occupation definition, as long as she is medically able to perform other commensurate work suited by education and training (such as teaching at a medical school), she would not qualify for benefits.

c. ✗ Incorrect. Introduces a non–disability definition. Extended health care reimburses eligible medical expenses and does not belong to the four–level disability spectrum measuring working capacity.

d. ✓ Correct. Across the four–level spectrum (own occupation –> regular occupation –> any occupation –> CPP total disability), own occupation sits at the most liberal end, requiring only that the insured cannot perform the essential duties of her specific occupation (orthopedic surgery), representing the lowest threshold to qualify for benefits.

91 answer c

a. ✗ Incorrect. Fabricates a statutory spending restriction. When a personal critical illness (CI) contract contains no restrictions on fund usage, the insured can indeed spend part of the payout on commercial rent and wages; using proceeds for business purposes is not legally prohibited.

b. ✗ Incorrect. Mistakenly assumes government programs pay business overhead. No government program covers commercial rent or employee salaries; business overhead must be addressed through commercial insurance or self–funding.

c. ✓ Correct. Relying on personal critical illness insurance as the sole business solution has two fundamental flaws: first, the claim triggers differ—a disabling injury or illness preventing work may not meet the strict definitions of covered conditions in a CI contract, whereas Business Overhead Expense (BOE) is triggered by disability and reimburses eligible overhead monthly; second, even if CI is triggered, a single lump sum forced to cover both family living and recovery costs as well as ongoing clinic rent and payroll will likely leave both underfunded. Advisors must assess personal cash flow and business overhead separately.

d. ✗ Incorrect. Confuses the benefit structure of BOE with CI. BOE reimburses eligible business overhead expenses incurred during the owner's disability under policy terms (with a distinct waiting period, monthly maximum, and benefit duration), rather than paying a lump sum upon critical illness diagnosis.

91′ answer a

a. ✓ Correct. As demonstrated in Case Study C, unrestricted CI payouts can legally be used to pay commercial rent and staff wages, but using one fixed lump sum for both household recovery living costs and ongoing business overhead easily leads to shortfalls; BOE specifically reimburses eligible business fixed expenses monthly under defined terms (including an elimination period, monthly maximum, and benefit period), so advisors must assess family cash flow and business overhead separately.

b. ✗ Incorrect. Fabricates a policy voidance penalty. Personal CI lump sums generally carry no restrictions on use, and spending proceeds on business expenses does not void the policy retroactively; the real risk is benefit exhaustion and mismatched claim triggers.

c. ✗ Incorrect. Inappropriately includes personal living expenses under BOE. BOE reimburses only eligible business operating overhead (such as commercial rent and non–owner staff wages), never personal household mortgages or grocery bills.

d. ✗ Incorrect. Overlooks ownership and beneficiary verification for corporate–owned insurance. If a corporate–owned critical illness structure is implemented, the advisor must strictly verify policyowner and beneficiary designations.

Chapter 14 answers and reasons

92 answer a

a. ✓ Correct. The individual own occupation definition is the most liberal on the four–level spectrum: as long as the insured cannot perform all essential duties of their specific occupation, they qualify for total disability, and taking another job or earning more does not reduce benefits. In contrast, the exam standard explicitly states that an own occupation clause in a group disability contract functions like an individual regular occupation definition, meaning benefits are reduced or terminated if the insured engages in other gainful employment.

b. ✗ Incorrect. Mistakenly equates group own occupation with individual own occupation. A group own occupation clause operates in practice like a regular occupation clause, meaning returning to work in another occupation cannot be combined with full disability benefits.

c. ✗ Incorrect. Terminating benefits because the insured can perform work matching education, training, and experience is the test for an any occupation definition, not an individual own occupation definition.

d. ✗ Incorrect. Completely inverts how individual and group policies treat own occupation: under individual own occupation, teaching does not reduce benefits, whereas group coverage reduces or terminates benefits upon returning to work.

92′ answer c

a. ✗ Incorrect. Only an individual own occupation definition allows collecting full benefits while working in another occupation. Group own occupation functions like regular occupation, precluding full benefits once a suitable reassignment is accepted.

b. ✗ Incorrect. An internal job reassignment is a return–to–work scenario that does not trigger a termination conversion privilege, nor does it automatically convert coverage into a non–cancellable policy.

c. ✓ Correct. The exam standard specifies that an own occupation clause in group disability insurance operates like an individual regular occupation clause: if the employer offers a suitable reassignment or the insured voluntarily resumes work, benefits are reduced or stopped, preventing the employee from drawing a full salary and full disability benefits simultaneously.

d. ✗ Incorrect. Disability policies contain no statutory rule doubling benefits upon returning to work; returning to work reduces or terminates benefits under regular occupation or rehabilitation provisions.

93 answer b

a. ✗ Incorrect. Directly multiplying $140,000 gross revenue by 60% overlooks deducting the $50,000 in operating expenses; self-employed insurable earnings must be based on net business income after deducting business expenses.

b. ✓ Correct. Underwriting self-employed applicants requires reporting insurable earned income based on net business income, which is gross revenue of $140,000 minus operating expenses of $50,000, equaling $90,000. Ongoing passive unearned income (such as $18,000 in rental income) must be listed separately and cannot be added to earned income to inflate coverage, making the maximum annual insurable benefit $90,000 x 60% = $54,000.

c. ✗ Incorrect. Erroneously adds $18,000 of passive rental income that continues during disability into insurable earned income; ongoing unearned income reduces insurance need or affects financial underwriting, but cannot increase insurable earned income limits.

d. ✗ Incorrect. Fails to deduct $50,000 in operating expenses while improperly adding $18,000 of ongoing rental income, doubly exaggerating the insurable earnings baseline.

93′ answer d

a. ✗ Incorrect. Fails to deduct $30,000 of operating expenses from $110,000 gross revenue; self-employed individuals cannot base disability coverage on gross billings.

b. ✗ Incorrect. Ongoing unearned income (such as $12,000 in trust distributions) is not interrupted by disability and must be listed separately rather than added to earned income to increase coverage.

c. ✗ Incorrect. Commits two errors simultaneously: failing to deduct operating expenses and including ongoing unearned income in earned income.

d. ✓ Correct. A self-employed individual's insurable earned income is net business income of $80,000 ($110,000 gross billings minus $30,000 operating expenses); ongoing trust dividends are excluded from earned income, yielding a maximum insurable annual benefit of $80,000 x 60% = $48,000.

94 answer a

a. ✓ Correct. The LLQP exam standard clearly specifies that Employment Insurance (EI) sickness benefits have a maximum benefit duration of 15 weeks following a one-week waiting period. While current statutory rules have extended this to 26 weeks (with the waiting period waived under certain temporary measures), candidates must answer 15 weeks on the exam unless a question explicitly provides current figures.

b. ✗ Incorrect. Neither 52 weeks nor a two-week waiting period reflects exam standard rules for EI sickness benefits, which prescribe up to 15 weeks after a one-week waiting period.

c. ✗ Incorrect. A 90-day waiting period and a 12-month benefit period are typical of commercial or group disability plans, not federal EI sickness benefits.

d. ✗ Incorrect. Paying four months after the onset of severe and prolonged disability is the rule for CPP disability benefits (CPP-D), not EI sickness benefits.

94′ answer b

a. ✗ Incorrect. Four weeks is far below the maximum benefit duration prescribed for EI sickness benefits.

b. ✓ Correct. The exam standard specifies that EI sickness benefits pay 55% of insurable earnings for up to 15 weeks following a one-week waiting period. Although Canadian federal law currently provides up to 26 weeks, questions testing exam reference materials require answering 15 weeks.

c. ✗ Incorrect. Sixty weeks is not a recognized benefit duration for EI sickness benefits.

d. ✗ Incorrect. A duration of 104 weeks (2 years) is typical of commercial disability benefit periods or definition-change milestones, not federal EI sickness benefits.

95 answer c

a. ✗ Incorrect. Ignores the offset effect of the all–source maximum; when the group master contract includes CPP–D and individual policies in the 85% pool, any excess directly reduces group LTD payments.

b. ✗ Incorrect. Fails to include the $1,500 individual benefit that the contract explicitly puts in the pool, and produces an impossible group payout higher than the original $3,600 benefit.

c. ✓ Correct. The all–source maximum is 85% x $6,000 = $5,100 per month. Because the master contract includes individual policies, total benefits equal group $3,600 + CPP–D $1,200 + individual $1,500 = $6,300, which exceeds the cap by $1,200 ($6,300 – $5,100). The excess reduces the group LTD benefit: $3,600 – $1,200 = $2,400 per month.

d. ✗ Incorrect. Erroneously deducts the individual benefit dollar–for–dollar instead of calculating the excess against the 85% all–source maximum pool.

95′ answer a

a. ✓ Correct. The all–source maximum is 85% x $6,000 = $5,100 per month. Because the master contract exempts individual policies, only group $3,600 + CPP–D $1,200 = $4,800 enters the pool. Since $4,800 is below the $5,100 cap, the group benefit is unreduced; adding the exempt $1,500 individual benefit yields a total nominal payout of $4,800 + $1,500 = $6,300 per month.

b. ✗ Incorrect. Mistakenly assumes 85% is an absolute statutory ceiling across all sources; when the master contract explicitly exempts personal policies, group plus CPP–D ($4,800) does not exceed $5,100, allowing total income to reach $6,300.

c. ✗ Incorrect. Omits the $1,500 individual disability benefit, arbitrarily assuming the personal policy pays zero.

d. ✗ Incorrect. When group plus CPP–D totals $4,800 (under the $5,100 cap) with no dollar–for–dollar offset, no reduction is triggered; there is no rule deducting half of the CPP–D benefit.

96 answer c

a. ✗ Incorrect. Erroneously deducts the 4–month waiting period from the 60–month benefit period; the waiting period and benefit period are independent and never offset each other.

b. ✗ Incorrect. Calculates 68 – 4 = 64 months but overlooks that the policy's benefit period is capped at 60 months, which must apply first.

c. ✓ Correct. The waiting period is the elimination interval before benefits begin, and the benefit period is the maximum duration payable, with neither offsetting the other. The initial 120 days (approximately 4 months) pay nothing; benefits commence at Month 5 and pay for the full 60–month cap (Months 5 through 64), leaving the remaining 4 months uncovered, totaling 60 payable months.

d. ✗ Incorrect. Violates the rule that waiting periods pay no benefits while ignoring the 60–month benefit period cap entirely.

96′ answer b

a. ✗ Incorrect. Deducts the 3–month waiting period from the 24–month benefit period cap, violating the rule that the waiting period and benefit period do not offset each other.

b. ✓ Correct. The waiting period and benefit period are independent: the initial 3 months pay no benefits, and the remaining 27 months of disability (30 – 3) exceed the 24–month benefit period cap, capping total payments at 24 months.

c. ✗ Incorrect. Subtracts the 3–month waiting period from 30 months of disability but forgets that the policy caps benefits at a maximum of 24 months.

d. ✗ Incorrect. Completely overlooks both the 3–month waiting period and the 24–month maximum benefit period.

97 answer d

a. ✗ Incorrect. Remembers that the recurring window waives a new waiting period, but overlooks that both disability periods combine under the same 24–month benefit period cap.

b. ✗ Incorrect. Because she returned to work for only 4 months (within the 6–month window) before relapsing from the same cause, it is treated as the same disability and does not require a new 90–day waiting period.

c. ✗ Incorrect. Requiring a new 90–day waiting period and resetting a 24–month benefit period applies only when relapsing outside the 6–month window; Grace returned to work for only 4 months, remaining inside the window.

d. ✓ Correct. Under the recurring disability clause, a relapse from the same cause within the 6–month window (here, 4 months of work) is treated as a continuation of the same disability. The benefit is waiving a new 90–day waiting period so payments resume immediately; the trade–off is combining both periods under the original 24–month cap, leaving only 10 payable months after deducting the 14 months already used.

97′ answer b

a. ✗ Incorrect. Grace returned to full–time work for 7 months, exceeding the 6–month recurring window, so the relapse is no longer treated as the same disability.

b. ✓ Correct. Because returning to work for 7 months exceeds the 6–month recurring disability window, this relapse is treated as a brand new disability: it requires satisfying a fresh 90–day waiting period, but resets the maximum benefit period to a full 24 months.

c. ✗ Incorrect. In disability insurance, waiving the waiting period and resetting the benefit period never happen together: relapses inside the window waive the waiting period but combine caps; relapses outside require a waiting period but reset the cap.

d. ✗ Incorrect. Expiration of the recurring window simply means the second disability is adjudicated as a new claim with a new waiting period and benefit period, not that the claim is denied.

98 answer b

a. ✗ Incorrect. Overlooks the standard medical–free conversion of non–cancellable policies to guaranteed renewable at age 65, while confusing the underwriting concept of guaranteed issue with a non–cancellable renewal guarantee.

b. ✓ Correct. Under the exam standard, a non–cancellable policyowner reaching age 65 can typically convert to a guaranteed renewable policy without medical evidence (with benefits shortened to 1 or 2 years and rates based on attained age, often continuing to age 72 or 75). In contrast, guaranteed issue is an entry underwriting method completely distinct from renewability provisions; a guaranteed issue plan can be cancellable and terminated unilaterally by the insurer.

c. ✗ Incorrect. Converting at age 65 transitions coverage to guaranteed renewable with rates based on attained age and benefit periods reduced to 1 or 2 years, rather than locking in original rates; furthermore, guaranteed issue does not freeze premiums.

d. ✗ Incorrect. The right of a non–cancellable policyowner to convert to a guaranteed renewable contract at age 65 does not require medical underwriting.

98′ answer c

a. ✗ Incorrect. Guaranteed issue is an underwriting standard (acceptance without individual medical evidence) rather than a renewability provision, and does not prevent the insurer from adjusting rates or cancelling coverage under a cancellable clause.

b. ✗ Incorrect. Raising premiums class–wide prior to age 65 is permitted under guaranteed renewable, not non–cancellable (Plan X locks premiums to age 65), and Plan Y as a cancellable policy does not lock premiums.

c. ✓ Correct. A non–cancellable policy locks in premiums and terms to age 65 with no cancellation, and typically allows medical–free conversion to guaranteed renewable up to age 72 or 75. Meanwhile, guaranteed issue applies only to initial enrollment; because its renewability provision is cancellable, the insurer retains the right to terminate the contract.

d. ✗ Incorrect. Non–cancellable policyowners can typically convert to a guaranteed renewable policy at age 65 without medical evidence to maintain coverage to age 72 or 75.

Chapter 15 answers and reasons

99 answer b

a. ✗ Incorrect. Confuses dying before the survival period ends with dying after completing the survival period but prior to claim approval (qualification period vs. survival period trap). Once the insured survives the 30–day survival period, the entitlement to the benefit is established and is not voided if death occurs during administrative processing.

b. ✓ Correct. The policy had been in force for six months (satisfying the qualification period), and Victor survived for 34 days following diagnosis (exceeding the 30–day survival period). Under policy design rules, when the insured dies after completing the survival period but before the claim is finalized, the critical illness benefit is still payable to the estate or named beneficiary.

c. ✗ Incorrect. Arbitrarily altering the contractual survival period based on clinical severity (subjective assumption trap). The survival period is determined strictly by the actual policy terms (specified as 30 days in the scenario) and cannot be extended to 90 days simply because the insured was in intensive care.

d. ✗ Incorrect. Mistaking the date of diagnosis as the starting point of the qualification period (qualification period vs. survival period trap). The qualification period runs from policy issue or reinstatement to prevent anti–selection, whereas the period starting upon diagnosis is the survival period.

99′ answer d

a. ✗ Incorrect. Focusing solely on the qualification period while ignoring the survival period (qualification period vs. survival period trap). Although the heart attack was diagnosed well after the 30–day qualification period expired, the insured must also survive for the full 30–day survival period following diagnosis to trigger the benefit.

b. ✗ Incorrect. Inventing a rule that pro–rates benefits based on days survived (fabricated rule trap). The survival period is an all–or–nothing condition; failing to complete the required 30 days results in no pro–rated payout.

c. ✗ Incorrect. Confusing the core purposes of critical illness insurance and life insurance (line of insurance confusion trap). Critical illness insurance is designed to provide funds for a living insured to rebuild their life; dying before the survival period ends does not convert the coverage into life insurance death benefits.

d. ✓ Correct. If the insured dies before completing the required survival period (19 days < 30 days), the condition is not satisfied and no critical illness benefit of $200,000 is payable (and no return of premium on death rider was purchased).

100 answer a

a. ✓ Correct. Under standard exam rules, the typical LTC elimination period range is 0 to 90 days (shorter periods result in higher premiums), and benefit models generally categorize home care under an expense reimbursement model and facility care under an indemnity model. Note: a verified current individual LTC product features waiting periods of 365 or 730 days with income-style indemnity for both settings; practical work requires verifying each contract, but exam questions follow the standard 0 to 90 day exam model.

b. ✗ Incorrect. Conflating specific current product waiting periods and incorrect payout models with general exam rules (treating market details as exam rules trap). The 365 or 730-day waiting periods and age 65 effective threshold are parameters of a specific current market product, not the standard 0 to 90-day exam framework.

c. ✗ Incorrect. Applying critical illness time gates and lump-sum payouts to long-term care insurance (cross-product confusion trap). Qualification periods, survival periods, and one-time lump-sum settlements belong to critical illness insurance, not long-term care insurance.

d. ✗ Incorrect. Reversing the relationship between elimination periods and premiums as well as the home versus facility care classifications (directional reversal trap). A shorter elimination period means the insurer begins paying sooner, resulting in higher premiums; furthermore, exam rules categorize home care as reimbursement and facility care as indemnity.

100′ answer c

a. ✗ Incorrect. Inverting the relationship between elimination period duration and premium cost (logical reversal trap). The longer the waiting period that the insured self-funds (the elimination period), the lower the premium; thus, Policy Y with a 90-day elimination period has a lower premium.

b. ✗ Incorrect. Mistaking the waiting period of a specific market product for the exam's minimum threshold (treating market details as exam rules trap). The exam framework provides an elimination period range of 0 to 90 days; 365 or 730 days are parameters found in specific current commercial products.

c. ✓ Correct. Within the exam's 0 to 90-day elimination period range, 30 days is shorter than 90 days, meaning the insured self-funds for a shorter duration and the insurer assumes risk sooner; therefore, Policy X has a higher premium than Policy Y. Note: while a verified current individual product has 365 or 730-day waiting periods, exam questions follow the standard 0 to 90-day model.

d. ✗ Incorrect. Confusing which line of insurance uses elimination periods (terminology misattribution trap). An elimination period is precisely the primary mechanism used in long-term care and disability insurance to manage premium costs.

101 answer c

a. ✗ Incorrect. Falling into the trap of determining claim eligibility based on colloquial disease names. The popular term "mini-stroke" cannot override the contract's strict definition; the clinical diagnosis was a transient ischemic attack (TIA), which the policy explicitly excludes.

b. ✗ Incorrect. Fabricating a statutory rule of automatic 50% partial benefits (fabricated rule trap). Whether partial or early-stage benefits exist depends strictly on specific contract provisions; there is no statutory rule mandating a half-benefit for temporary symptoms.

c. ✓ Correct. Claim adjudication must be based strictly on exact contract definitions and objective medical evidence rather than colloquial labels like "mini-stroke." Because Kevin's clinical diagnosis was a transient ischemic attack (TIA) with rapidly resolving symptoms, no permanent neurological deficit, and TIA is explicitly excluded under the policy, it does not meet the contractual definition of a covered stroke.

d. ✗ Incorrect. Assuming that satisfying the survival period overrides the medical condition definition (prerequisite omission trap). The survival period applies only after the condition first meets the policy's covered critical illness definition; if the condition does not qualify, surviving any length of time will not trigger a payout.

101′ answer a

a. ✓ Correct. Critical illness insurance claims depend strictly on precise contractual definitions regarding medical severity. Although the medical name includes "carcinoma," ductal carcinoma in situ is explicitly excluded under this contract and no early-stage benefit rider was purchased, meaning it does not satisfy the covered cancer definition.
b. ✗ Incorrect. Misidentifying the Big 4 core conditions (Big 4 concept trap). Cancer, along with heart attack, stroke, and coronary artery bypass surgery, is one of the Big 4 core conditions; the claim is denied because the condition does not meet the required contractual severity, not because cancer is omitted from coverage.
c. ✗ Incorrect. Confusing surgical outcome with contractual condition definitions (causal dislocation trap). The claim is denied because the pathology confirmed non-invasive carcinoma in situ, which the policy explicitly excludes, not because the surgical excision was curative.
d. ✗ Incorrect. Confusing critical illness triggers with disability insurance triggers (line of insurance confusion trap). Critical illness insurance does not evaluate whether an insured can return to work; it evaluates solely whether the diagnosis meets the policy definition and the survival period is satisfied.

102 answer d

a. ✗ Incorrect. Falling into the trap of assuming critical illness coverage continues indefinitely like medical reimbursement. Even though heart attack and cancer are both Big 4 conditions, a traditional critical illness policy without a second event rider terminates upon a 100% full payout and will not pay a second full benefit.
b. ✗ Incorrect. Fabricating an automatic 50% second-claim rule without a rider (fabricated rule trap). The original policy terminated upon paying the 100% full claim in 2021, and there is no automatic entitlement to a half-benefit for a subsequent illness.
c. ✗ Incorrect. Confusing waiver of premium with policy termination (provision confusion trap). A waiver of premium rider waives ongoing premiums while a policy is active during total disability; it cannot resurrect a policy that already terminated upon a full claim settlement.
d. ✓ Correct. When a policy terminates upon paying a full critical illness benefit and the insured did not purchase a second event rider, the contract terminated upon the $100,000 payout in 2021; the 2025 heart attack cannot generate any benefit from that policy.

102′ answer b

a. ✗ Incorrect. Equating an early partial payout with full claim termination (full vs. partial benefit confusion trap). In policies that distinguish full-payout conditions from early-stage conditions, an early partial benefit does not automatically terminate the underlying contract.
b. ✓ Correct. Whether an early partial benefit reduces the base face amount or preserves base coverage depends on specific contract terms, and does not automatically terminate the policy; furthermore, even with a second event rider, a subsequent claim must still satisfy covered condition definitions, required waiting intervals between events, and survival periods.
c. ✗ Incorrect. Assuming that purchasing a second event rider guarantees unconditional payouts for any subsequent illness (infallible rider trap). A second claim must still strictly satisfy specific covered condition definitions, required separation intervals between events, and survival periods.
d. ✗ Incorrect. Confusing critical illness benefits with conversion to disability income insurance (cross-product grafting trap). An early partial benefit under a critical illness policy does not convert the remaining coverage into monthly disability income benefits.

103 answer c

a. ✗ Incorrect. Equating isolated expressive speech difficulties with cognitive impairment (cognitive impairment criteria trap). The cognitive impairment test requires documented cognitive deterioration necessitating continual supervision for safety; minor word–finding difficulty alone does not qualify as cognitive impairment.

b. ✗ Incorrect. Misremembering the required threshold of impaired ADLs (numerical threshold trap). Standard activities of daily living (ADLs) criteria require that the insured be unable to perform at least 2 of the 6 ADLs independently; impairment in only 1 ADL (transferring) fails to meet the threshold.

c. ✓ Correct. The two primary benefit triggers for LTC insurance are: 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. Leonard requires assistance with only 1 ADL and has mild word–finding difficulty without needing continual supervision, failing both triggers.

d. ✗ Incorrect. Exaggerating "at least two" ADLs into requiring all six (threshold exaggeration trap). Exam rules require an inability to perform at least 2 of the 6 ADLs independently; total failure of all six ADLs is not required.

103′ answer a

a. ✓ Correct. The cognitive impairment test is an independent alternative trigger alongside the six activities of daily living (ADLs); when an insured suffers cognitive deterioration requiring continual supervision to protect their health and safety, they qualify for LTC benefits once the effective date and elimination period requirements are satisfied, even if they remain physically capable of performing all six ADLs.

b. ✗ Incorrect. Mistaking an "or" relationship for an "and" requirement (logical conjunction trap). Impairment in at least two ADLs and severe cognitive impairment requiring continual supervision are alternative standalone triggers; satisfying both simultaneously is not required.

c. ✗ Incorrect. Confusing critical illness coverage with long–term care coverage scopes (cross–coverage exclusion trap). Cognitive deterioration resulting from illness, injury, or aging that requires continual supervision is precisely a core coverage scenario intended for long–term care insurance.

d. ✗ Incorrect. Confusing regular long–term care benefits with respite care benefits (conceptual confusion trap). Respite care provides short–term temporary relief to unpaid family caregivers, whereas Evelyn satisfies the cognitive impairment trigger and qualifies for standard ongoing LTC benefits.

104 answer c

a. ✗ Incorrect. Mistaking voluntary industry guidelines for mandatory provincial law (overgeneralization trap). The CLHIA explicitly states that adoption of its benchmark definitions by member companies is entirely voluntary, not a statutory mandate.

b. ✗ Incorrect. Assuming that Big 4 definitions are completely identical across all insurers (overgeneralization trap). Even for Big 4 conditions like heart attack, specific diagnostic criteria and contractual wording can vary between carriers and policy vintages, requiring verification of each specific contract.

c. ✓ Correct. The CLHIA CI Benchmark Definitions (current 2024 Final version, preceded by 2018 and 2013 versions) are adopted voluntarily by insurers rather than being mandatory statutory standards; therefore, an advisor cannot assume that heart attack definitions are identical across carriers, and must verify the exact wording in the client's policy contract.

d. ✗ Incorrect. Misattributing CLHIA benchmarks to an unrelated insurance product (terminology misattribution trap). The CLHIA CI Benchmark Definitions were developed specifically for critical illness insurance, not group disability insurance.

104′ answer b

a. ✗ Incorrect. Confusing the Big 4 with activities of daily living (terminology confusion trap). The Big 4 refers to the four core critical illness conditions (heart attack, stroke, cancer, and coronary artery bypass surgery), whereas ADLs are the six self–care activities used in long–term care insurance.

b. ✓ Correct. The Big 4 conditions represent the core illness combination used in the exam to teach common critical illnesses rather than a statutory minimum coverage mandate (basic market plans may cover only 3 conditions or even a single condition like cancer or heart disease); furthermore, CLHIA benchmark definitions are voluntary, meaning exact contractual definitions vary by insurer.

c. ✗ Incorrect. Contradicting the established market tiers of critical illness insurance (market structure trap). Both exam standards and current market reality offer basic 3– or 4–condition plans, 10–condition plans, and comprehensive 20+ condition policies.

d. ✗ Incorrect. Assuming that attending physicians determine policy definitions (claim authority trap). Physicians provide medical diagnoses and clinical evidence, but whether a condition qualifies for benefits is governed strictly by the pre–established contractual definitions in the insurance policy.

105 answer d

a. ✗ Incorrect. Confusing an expense reimbursement model with a fixed indemnity model (model confusion trap). Owen's policy uses a reimbursement model for home care, paying eligible actual daily expenses ($100 per day) up to the daily cap, rather than paying an unspent $150 daily indemnity.

b. ✗ Incorrect. Falling into the trap of overlooking the carry–forward of unused daily LTC benefits. Under the exam model where reimbursements are deducted from an aggregate benefit pool, the unused $50 daily balance is not forfeited, but remains in the pool to extend coverage to subsequent days.

c. ✗ Incorrect. Treating the actual invoice as a deductible and reimbursing only the difference (differential miscalculation trap). Because the actual daily cost of $100 is below the $150 daily maximum benefit, the full $100 is reimbursed, rather than paying the $50 difference.

d. ✓ Correct. Under the exam's reimbursement model governed by an aggregate maximum benefit pool, when eligible actual daily expenses ($100) are below the daily maximum benefit ($150), the insurer reimburses $100 per day, and the unused $50 daily balance carries forward within the $54,750 total pool, extending coverage up to $54,750 / $100 = 547.5 days.

105′ answer b

a. ✗ Incorrect. Falling into the trap of overlooking the carry–forward of unused daily LTC benefits. Simply applying the nominal 730–day period ignores the fact that spending $40 less each day keeps funds within the total pool to extend the benefit period.

b. ✓ Correct. Because eligible actual daily expenses ($160) are below the daily maximum benefit ($200), the unused balance carries forward to fund subsequent days until the total pool of $146,000 is exhausted, yielding a total benefit period of $146,000 / $160 = 912.5 days.

c. ✗ Incorrect. Erroneously using the $40 difference between the daily cap and the invoice as the divisor (differential miscalculation trap). The insurer reimburses the actual daily expense of $160; therefore, $146,000 must be divided by $160, not by $40.

d. ✗ Incorrect. Fabricating a rule that home care reduces the total benefit pool by 20% (fabricated rule trap). Spending only 80% of the daily maximum ($160 / $200) allows the benefit pool to last longer (dividing days by 0.8), rather than multiplying the nominal days by 0.8.

Chapter 16 answers and reasons

106 answer b

a. ✗ Incorrect. Reversing the calculation order of deductible and co-insurance. Multiplying $800 directly by 80% to get $640 completely omits the mandatory first step of deducting the $100 unused annual deductible, and fails to recognize that the insured must pay both the deductible and the 20% co-insurance share on the remaining balance.

b. ✓ Correct. When both a deductible and a co-insurance factor apply, calculations must follow a strict two-step sequence: subtract first, then multiply. First, deduct the $100 annual deductible from the $800 bill to arrive at a $700 balance; the insurer then reimburses 80% of $700, which equals $560. Elena's out-of-pocket cost is the $100 deductible plus her 20% co-insurance share of $140 ($700 * 20%), totaling $240.

c. ✗ Incorrect. Overlooking the co-insurance cost sharing. The $700 balance remaining after subtracting the $100 deductible is not covered in full by the insurer; it must be multiplied by the 80% co-insurance factor, leaving the insured responsible for the remaining 20% ($140).

d. ✗ Incorrect. Ignoring cost-sharing mechanisms. Extended health and dental policies use deductibles and co-insurance factors to mitigate moral hazard and will not reimburse the entire $800 bill when the contract specifies an annual deductible and an 80% co-insurance factor.

106′ answer c

a. ✗ Incorrect. Confusing the scope of provincial healthcare coverage. British Columbia's Medical Services Plan (MSP) does not cover routine dental care or major restorative dental procedures like crowns and bridges; the remaining 50% must be paid out of pocket by the insured.

b. ✗ Incorrect. Confusing the billing method with co-insurance rules. Regardless of whether direct billing is utilized at the dental clinic, the co-insurance factor for major restorative procedures is strictly governed by the contractual 50% rate.

c. ✓ Correct. After deducting the $100 annual deductible from $800 to leave a $700 balance, the insurer applies a lower 50% co-insurance factor rather than the 75% to 80% routine rate because crowns and bridges represent major restorative work. Setting a lower reimbursement rate on costlier, less predictable procedures is designed to curb moral hazard by increasing the insured's financial participation.

d. ✗ Incorrect. Confusing fee schedule limits with procedure categorization. Applying a 50% co-insurance factor to major restorative work is a structural policy feature based on procedural tier and cost, not a penalty for exceeding the provincial dental fee schedule.

107 answer a

a. ✓ Correct. Dental claims are capped based on the fee schedule specified in the contract. When a dentist's actual charge exceeds the fee schedule amount, the excess is not a claim denial; rather, the excess was never an eligible covered expense under the policy. The insurer properly paid 80% of the approved fee schedule amount, and Tariq is responsible for paying the uninsured difference.

b. ✗ Incorrect. Confusing dental procedure tiers. Fillings, cleanings, and diagnostic X-rays are classified as routine maintenance (typically covered at 75% to 80%), whereas crowns, bridges, and implants are major restorative procedures that typically drop to 50% co-insurance.

c. ✗ Incorrect. Confusing liability and provincial healthcare coverage. The provincial dental association fee guide provides suggested rates and serves as a contractual benchmark for insurers. A dentist charging above the fee guide is not violating provincial healthcare regulations, and MSP does not reimburse the excess difference.

d. ✗ Incorrect. Confusing direct billing with claim adjudication rules. Whether a claim is processed through direct billing at the clinic or submitted manually for reimbursement, the contractual deductible, co-insurance factor, and fee schedule limits apply in the exact same manner.

107′ answer d

a. ✗ Incorrect. Mistaking an excess charge for an outright claim denial. A policy that bases formulary reimbursement on generic equivalents does not void the entire claim if the insured chooses a brand-name drug; instead, the insurer pays its share up to the generic price, and the insured pays the difference out of pocket.

b. ✗ Incorrect. Confusing the scope of MSP coverage. British Columbia's Medical Services Plan (MSP) does not cover outpatient prescription drugs and will not pay the cost difference resulting from an insured choosing a brand-name medication.

c. ✗ Incorrect. Misunderstanding the function of direct billing. Direct billing simply allows the pharmacy to deduct the insurer's covered portion immediately at point of sale; it does not waive or absorb the out-of-pocket price difference between brand-name and generic drugs.

d. ✓ Correct. To manage moral hazard and rising medication costs, extended health policies commonly utilize formularies that cap reimbursement at the lowest-cost generic equivalent. If an insured chooses a brand-name drug, the excess price difference above the generic benchmark is an out-of-pocket expense paid by the insured, analogous to dental charges exceeding a fee schedule.

108 answer c

a. ✗ Incorrect. Erroneously crediting co-insurance amounts toward the family deductible. From the spouse's previous $60 claim, only $50 was credited toward her individual deductible and the family deductible, with the remaining $10 entering co-insurance; thus, the family deductible accumulated prior to the child's claim was $100, not $140.

b. ✗ Incorrect. Overlooking the individual deductible cap per person. The maximum amount any single member can contribute to the deductible is the $50 individual annual cap. For the child's $60 claim, only $50 can be applied to the deductible while the remaining $10 enters co-insurance, so the family deductible cannot reach $170.

c. ✓ Correct. Devon's $50 and the first $50 of the spouse's $60 claim previously credited $100 toward the family deductible. When the child submits a $60 claim, $50 satisfies the child's individual deductible and brings the family deductible total to exactly $150, while the remaining $10 enters co-insurance. Because the $150 family deductible cap is now met, the deductible is fully satisfied and cleared for all family members for the rest of the year.

d. ✗ Incorrect. Misunderstanding the trigger conditions for the family deductible. The family deductible waives remaining individual deductibles only after aggregate family contributions reach the full $150 limit. Devon and his spouse contributed only $100 in total ($50 each), which was insufficient to trigger the $150 family threshold.

108′ answer a

a. ✓ Correct. The family deductible serves as an independent overarching trigger. Once three family members contribute $50 each to meet the $150 family deductible cap, the deductible requirement is completely satisfied for the entire family for the remainder of the calendar year, meaning subsequent claims from any family member bypass the deductible and go directly to co-insurance.

b. ✗ Incorrect. Focusing solely on individual deductibles while ignoring the family trigger. The individual and family deductibles operate as dual alternative thresholds; once the $150 family total is satisfied, no other family member is required to satisfy an individual $50 deductible for the rest of that year.

c. ✗ Incorrect. Treating the family deductible as an open-ended multiple of family members. The family deductible is a fixed contractual ceiling ($150 in this scenario) rather than an amount that increases by $50 for each additional family member enrolled.

d. ✗ Incorrect. Confusing deductible satisfaction with eliminating co-insurance. Meeting the $150 family deductible eliminates only the deductible requirement for subsequent claims; eligible expenses must still be shared according to the contractual co-insurance factor.

109 answer d

a. ✗ Incorrect. Overextending a pre-existing condition exclusion to unrelated claims. Adjusting medication 130 days before departure breaches the 180-day stability period, creating a pre-existing condition exclusion that denies claims directly related to the heart condition. In the absence of material misrepresentation, it does not void the entire travel policy.

b. ✗ Incorrect. Confusing trip duration with the pre-departure stability look-back period. The stability period measures the elapsed days between the treatment change and the departure date (130 days vs. the required 180 days); it is never evaluated by comparing trip length (90 days) against the medication adjustment timeline.

c. ✗ Incorrect. Confusing general exam ranges with specific contractual terms. The exam standard identifies 90 to 180 days as typical stability periods, but the scenario explicitly specifies a 180-day contractual requirement. Under both exam principles and practice, 130 days fails the 180-day threshold, so the heart attack claim is denied.

d. ✓ Correct. Under exam rules, stability periods typically range from 90 to 180 days (evaluated using the specific days stated in the scenario). Because 130 days is shorter than the contractual 180-day requirement, expenses directly related to the heart attack are excluded; however, the broken leg resulted from an unrelated accidental fall and remains covered, provided there was no material misrepresentation and all other policy terms are met.

109′ answer b

a. ✗ Incorrect. Assuming that the absence of upfront underwriting means unrestricted coverage. Not requiring a detailed medical questionnaire when charging the trip does not eliminate pre-existing condition exclusions; credit card policies simply defer detailed medical record verification to the time a claim is filed.

b. ✓ Correct. Credit card travel insurance applies eligibility criteria, age limits, trip duration restrictions, and pre-existing condition stability clauses just like standalone policies. The absence of an upfront medical questionnaire does not grant open-ended coverage, as the insurer will review medical records at claim time to strictly verify compliance with the stability period and certificate of insurance.

c. ✗ Incorrect. Making absolute assumptions about coverage categories. Many credit cards do provide out-of-country emergency medical coverage, but their age limits, covered travel days, and stability clauses are often more restrictive than standalone policies, requiring careful review of the certificate of insurance.

d. ✗ Incorrect. Exaggerating out-of-country provincial healthcare coverage. British Columbia's Medical Services Plan (MSP) provides very limited reimbursement for emergency medical care outside Canada and will never automatically absorb high foreign hospital bills denied by commercial travel insurers.

110 answer a

a. ✓ Correct. Employer group plans offer low premiums and guaranteed-issue benefits that should not be casually forfeited. Under standard needs analysis, the appropriate recommendation is to retain the group coverage and purchase targeted individual policies solely to fill the identified gaps—such as AD&D, vision or orthodontic shortfalls, hospital room upgrades, and out-of-country travel medical insurance—without duplicating existing benefits.

b. ✗ Incorrect. Replacing group benefits with an individual plan. Advising a client to opt out of an employer group plan sacrifices employer premium contributions and non-underwritten coverage, while individual replacement policies are typically medically underwritten and carry significantly higher premiums.

c. ✗ Incorrect. Misunderstanding group master contract rules. Group insurance is negotiated between the employer and insurer as a standardized master package for an entire employee class; an insurer will not alter the master contract limits solely for an individual employee.

d. ✗ Incorrect. Blindly purchasing duplicate coverage. Buying an overlapping comprehensive individual health plan wastes premium dollars on already covered items while potentially failing to properly address standalone needs such as travel medical insurance or AD&D riders.

110′ answer b

a. ✗ Incorrect. Mistaking commercial plan design choices for statutory prohibitions. Provincial law does not prohibit group plans from covering private hospital rooms, AD&D, or travel medical care; omitting or capping these benefits reflects the employer's budget and package design trade-offs.

b. ✓ Correct. Group packages and individual customized plans reflect contrasting design philosophies. Group plans are negotiated by employers as uniform, one-size-fits-all packages for an entire employee class, delivering low group rates and non-underwritten coverage. In contrast, individual plans allow clients to select deductibles, co-insurance factors, and customized benefit limits to meet personal needs, but they almost always require medical underwriting and carry higher premiums.

c. ✗ Incorrect. Confusing the purpose of the Employer Health Tax (EHT). The Employer Health Tax is a provincial tax that the British Columbia government has levied on employers since 2019; it has nothing to do with subsidizing the vision or dental maximums of private individual health plans.

d. ✗ Incorrect. Inverting underwriting rules. A primary benefit of group insurance is that members join without individual medical underwriting, whereas individual customized plans generally require underwriting (and for medical expense reimbursement insurance, underwriting checks health status; it does not copy the income and financial underwriting used for disability income insurance).

111 answer c

a. ✗ Incorrect. Mistakenly assuming that AD&D always pays the full benefit. AD&D does not pay 100% of the principal sum for every injury; only death, loss of two limbs, or loss of sight in both eyes qualifies for 100%, while other specified losses are paid according to the graduated schedule of loss.

b. ✗ Incorrect. Confusing the tiers on the schedule of loss. In standard exam illustrations, 67% (or 75%) corresponds to the loss of one limb or sight in one eye, speech is 50%, and loss of hearing in one ear corresponds to 33%.

c. ✓ Correct. AD&D riders pay benefits according to a graduated schedule of loss based on injury severity (the exam standard illustrates a 365-day time limit and specific percentage tiers, which candidates must follow as presented in the question stem). Because the permanent hearing loss in one ear occurred 90 days after the accident (within the 365-day limit), the rider pays 33% of the principal sum.

d. ✗ Incorrect. Ignoring the contractual time window. AD&D does not require the specified loss to occur on the exact date of the accident; coverage applies as long as the loss occurs within the contractual window (illustrated here as within 365 days, which the 90-day mark satisfies).

111′ answer a

a. ✓ Correct. The exam illustrates AD&D benefits using a graduated schedule of loss based on severity. The permanent loss of speech occurred 180 days after the accident, which is within the 365-day window, and corresponds to a 50% payout of the principal sum under this schedule.

b. ✗ Incorrect. Confusing schedule of loss percentages. In exam illustrations, 75% (or 67%) applies to the loss of a single limb or sight in one eye, whereas loss of speech is assigned a 50% payout tier.

c. ✗ Incorrect. Mistakenly assuming a 100% payout for complete loss of speech. Even though the loss of speech is permanent and total, it does not qualify for the 100% tier on an AD&D schedule of loss, which is reserved for death, loss of two limbs, or loss of sight in both eyes.

d. ✗ Incorrect. Confusing travel stability periods with the AD&D loss window. Look-back periods of 90 to 180 days apply to travel insurance stability rules, whereas this AD&D provision explicitly allows 365 days from the accident date, making 180 days fully eligible.

112 answer b

a. ✗ Incorrect. Overlooking age–based vision exclusions. British Columbia's MSP explicitly excludes routine eye examinations for healthy adults aged 19 to 64; eye exams for this age group must be paid out of pocket or reimbursed through private extended health insurance.

b. ✓ Correct. The exam standard refers generically to provincial health care plans, which in British Columbia corresponds to MSP. MSP primarily covers medically necessary physician services and a very small number of in–hospital oral surgeries. Routine dental cleanings, routine eye exams for adults aged 19 to 64, and paramedical services like physiotherapy (unless qualifying under supplementary assistance) are excluded from general MSP coverage and represent the exact bills private extended health and dental insurance are designed to cover.

c. ✗ Incorrect. Equating premium elimination with coverage expansion. British Columbia eliminated personal MSP premiums on January 1, 2020, to change how healthcare is funded; this reform did not expand MSP's statutory scope of covered healthcare services.

d. ✗ Incorrect. Confusing paramedical coverage rules. Paramedical services such as physiotherapy, chiropractic care, massage therapy, acupuncture, and naturopathy are not covered by MSP for the general population and represent a core coverage category under private extended health insurance.

112′ answer a

a. ✓ Correct. Provincial health care plans (MSP in BC) cover medically necessary doctor and hospital services, while the initial phase of the federal Pharmacare Act and provincial initiatives covers only specific listed items such as contraceptives and diabetes medications. Even after factoring in public coverage, substantial gaps remain for routine dental, vision care, paramedical services, hospital room upgrades, and a wide array of prescription drugs, which is why private extended health insurance is needed.

b. ✗ Incorrect. Mistaking exclusions from basic MSP for an absolute absence of government funding. Specialized public programs (such as Plan NP and Fair PharmaCare, or the rare in–hospital dental surgeries MSP covers) provide assistance for certain drugs or vulnerable groups; advisors must account for available public programs before evaluating private insurance gaps.

c. ✗ Incorrect. Misunderstanding insurance mandates. Eliminating personal MSP premiums in 2020 did not make private extended health insurance mandatory; purchasing private coverage remains entirely optional based on individual needs analysis.

d. ✗ Incorrect. Confusing expense reimbursement insurance with disability income insurance. Disability insurance replaces lost earned income when an illness or injury prevents working, whereas extended health, dental, and travel insurance reimburse eligible out–of–pocket medical bills.

Chapter 17 answers and reasons

113 answer a

a. ✓ Correct. For the revenue decline and recruitment/training costs resulting from the disability of key employee Elena (loss of key employee), the company should own and be the beneficiary of key person disability insurance; for a co-owner's long-term disability requiring exit and share monetization (inability to sell), buy-sell disability buyout insurance tied to a buy-sell agreement with an elimination period of 12 to 24 months should be arranged.

b. ✗ Incorrect. Falls into the Product Functional Mismatch trap: Business overhead expense (BOE) insurance requires the insured life to be the business owner rather than a non-shareholder employee, and it does not reimburse the insured's own lost income; furthermore, key person disability insurance has a benefit period generally not exceeding 12 months to absorb short-term operational shocks, and cannot replace disability buyout insurance with its extended elimination period to purchase shares.

c. ✗ Incorrect. Falls into the Beneficiary and Purpose Mismatch trap: Elena is merely an employee rather than an equity partner, so disability buyout insurance does not apply to her; simultaneously, BOE only reimburses monthly fixed operating expenses such as rent, utilities, and staff salaries, and can never be used for share redemption or equity purchase.

d. ✗ Incorrect. Falls into the Benefit Tool Confusion trap: A Private Health Services Plan (PHSP) only reimburses health expenses such as dental and prescription drugs; business loan protection disability insurance is dedicated solely to servicing eligible commercial loan principal and interest, and neither addresses key person replacement or equity buyouts.

113′ answer c

a. ✗ Incorrect. Falls into the Product Functional Mismatch trap: Hannah is the sole owner, and needing to cover office rent and employee salaries during short-term disability represents an inability-to-work exposure rather than an equity buyout; Lucas is a non-shareholder employee and cannot be the insured business owner under a BOE policy.

b. ✗ Incorrect. Falls into the Scope Confusion trap: Business loan protection disability insurance only services eligible commercial loan principal and interest, without reimbursing office lease payments or bookkeeper salaries; a PHSP only reimburses medical bills and does not compensate the firm for revenue losses caused by a key employee's disability.

c. ✓ Correct. During sole owner Hannah's temporary disability, continuing fixed office lease and staff salary expenses should be covered by business overhead expense (BOE) insurance; for the revenue losses and replacement costs resulting from key manager Lucas being disabled for six months, key person disability insurance should be configured, with both policies owned by and payable to the business.

d. ✗ Incorrect. Falls into the Beneficiary Mismatch trap: The beneficiary of key person disability insurance is always the business entity itself, so claim payouts cannot be deposited directly into key employee Lucas's personal account.

114 answer b

a. ✗ Incorrect. Falls into the Overlooking the Carryover Provision trap: The policy includes a carryover provision, allowing the $1,500 in unused benefit from Month 1 ($10,000 – $8,500) to carry forward into Month 2 to reimburse eligible expenses exceeding the monthly limit.

b. ✓ Correct. First, exclude ineligible expenses: Owner Chloe's personal salary draw ($6,000) and commercial loan principal repayment ($2,000) are not eligible for reimbursement under business overhead expense (BOE) insurance. Eligible fixed overhead in Month 2 equals $9,200 (rent, staff wages, utilities) + $1,500 (commercial loan interest) = $10,700. Because actual reimbursement in Month 1 was $8,500, the remaining $1,500 unused limit carries over into Month 2, enabling the entire $10,700 of eligible expenses to be reimbursed in full (utilizing the $10,000 monthly limit plus $700 of the carried-over amount).

c. ✗ Incorrect. Falls into the BOE Scope Confusion trap: Under commercial loans, only interest is reimbursable, while principal repayments are strictly ineligible and cannot be counted as eligible expenses to exhaust the $1,500 carryover from Month 1.

d. ✗ Incorrect. Falls into the BOE Scope Confusion and Advance Borrowing trap: BOE strictly excludes the owner's personal salary or income replacement, and the carryover mechanism never permits borrowing unearned limits from future months in advance.

114′ answer a

a. ✓ Correct. First, exclude non-reimbursable commercial loan principal ($1,200) and capital expenditures for purchasing new equipment ($3,500). Month 2 eligible fixed expenses are $5,800 (rent and employee wages) + $700 (loan interest) = $6,500. Month 1 unused carryover ($6,000 – $5,100 = $900) is more than sufficient to cover Month 2's $500 excess over the cap, resulting in an actual reimbursement of $6,500.

b. ✗ Incorrect. Falls into the Overlooking the Carryover Provision trap: The policy includes a carryover provision, allowing the $900 in unused benefit from Month 1 to carry forward and be used in Month 2.

c. ✗ Incorrect. Falls into the BOE Scope Confusion trap: Commercial loan principal cannot be reimbursed under BOE; only the $700 loan interest constitutes an eligible expense.

d. ✗ Incorrect. Falls into the BOE Scope Confusion trap: Purchasing new equipment represents a new capital expenditure, which is not on the BOE reimbursable list designed to maintain minimum baseline operations.

115 answer c

a. ✗ Incorrect. Falls into the Tax Treatment Reversal and Duplicate Claim trap: The tax treatments of the two products are exact opposites, with no double tax benefit of deductible premiums and tax-free benefits; furthermore, business loan protection disability insurance and BOE cannot duplicate claims on the same loan.

b. ✗ Incorrect. Falls into the Tax Treatment Reversal trap: It completely reverses the tax rules between business overhead expense (BOE) insurance and business loan protection DI.

c. ✓ Correct. Business overhead expense (BOE) insurance premiums are tax-deductible as business operating expenses, but claim benefits are taxable; business loan protection disability insurance premiums are non-deductible, but benefits are tax-free. Furthermore, if a commercial loan's interest is already included in BOE reimbursable expenses, business loan protection insurance cannot duplicate claims on the same commercial loan.

d. ✗ Incorrect. Falls into the BOE Scope Confusion and Tax Rules trap: BOE reimburses only commercial loan interest ($1,800) and not loan principal ($3,200); in addition, BOE claim benefits constitute taxable income rather than tax-free proceeds.

115′ answer a

a. ✓ Correct. Business loan protection disability insurance premiums are non–deductible and benefits are tax–free, dedicated specifically to servicing eligible commercial loan principal and interest; conversely, business overhead expense (BOE) premiums are tax–deductible and benefits are taxable, and BOE reimburses only loan interest (excluding principal), with neither policy permitted to duplicate claims on the same loan.

b. ✗ Incorrect. Falls into the Tax Treatment Reversal trap: Premiums for business loan protection disability insurance are not tax–deductible and its claim benefits are tax–free; one cannot infer that insurance premiums are deductible simply because commercial loan interest itself is deductible.

c. ✗ Incorrect. Falls into the Tax Rules and Cross–Period Offset Promise trap: BOE premiums are indeed tax–deductible as business expenses; while taxable benefits and deductions for eligible expenses may offset each other, their amounts, recognition tax years, and qualifications may not be identical, so a net zero tax effect cannot be guaranteed in any year.

d. ✗ Incorrect. Falls into the Duplicate Claim trap: Business loan protection disability insurance and BOE cannot duplicate claims on the same commercial loan.

116 answer c

a. ✗ Incorrect. Falls into the Treating Range as Universal Disqualification trap: Under exam conventions, the shareholding cap falls between 10% and 50%, meaning different products establish specific underwriting ceilings within that range (for instance, if a product sets a 50% limit, 15% ownership is fully eligible); it does not mean any shareholding between 10% and 50% automatically disqualifies an employee.

b. ✗ Incorrect. Falls into the Beneficiary Mismatch and Valuation Formula Confusion trap: Key person disability insurance is owned by and payable to the business, not the employee's family; furthermore, its benefit period generally does not exceed 12 months, and coverage is calibrated to short–term monthly salary multiples and insurer monthly caps rather than copying key person life insurance's long–term gross profit contribution formula.

c. ✓ Correct. Under key person disability insurance, the business entity is the policyowner and sole beneficiary; exam conventions commonly feature waiting periods of 30 to 90 days, benefit periods not exceeding 12 months, benefit limits up to 100% of annual salary, and standard industry monthly caps of approximately $15,000 per month (Tariq's $12,000 monthly salary falls well within this); an attached replacement expense rider can directly reimburse headhunter fees and double–salary training costs.

d. ✗ Incorrect. Falls into the Waiting Period Confusion trap: An elimination period of 12 to 24 months applies to buy–sell disability buyout insurance; key person disability insurance is designed to bridge the short–term transition window for recruiting and training, with waiting periods typically between 30 and 90 days and benefit periods rarely exceeding 12 months.

116′ answer b

a. ✗ Incorrect. Falls into the Valuation Formula Confusion trap: Key person life insurance insures against a permanent, catastrophic long–term loss, whereas key person disability insurance has a benefit period rarely exceeding 12 months, focusing its valuation logic on the firm's monthly replacement costs and monthly salary limits over a finite window.

b. ✓ Correct. Key person disability insurance is owned by and payable to the business, typically features a waiting period of 30 to 90 days, a benefit period not exceeding 12 months, and exam benchmark limits of 100% of annual salary or approximately $15,000 per month, and can include waiver of premium, recurrent disability clauses, and a replacement expense rider.

c. ✗ Incorrect. Falls into the Beneficiary Mismatch trap: The beneficiary of key person disability insurance is always the business (BioLab Corp.) to offset corporate revenue loss and replacement recruitment expenses, and benefits are never paid directly to the individual employee.

d. ✗ Incorrect. Falls into the Treating Range as Fixed Statutory Limit trap: Under exam conventions, 10% to 50% represents the common industry range for ownership limits rather than a single statutory mandate, as internal underwriting rules vary among insurers.

117 answer d

a. ✗ Incorrect. Falls into the Overlooking Post–Age–60 Reduction trap: In exam examples, buy–sell disability buyout insurance reduces coverage by 20% per year after age 60 rather than maintaining the original level face amount.

b. ✗ Incorrect. Falls into the Disability Definition Level Confusion trap: Buyout insurance commonly requires that the insured is unable to perform regular occupation duties and is not working at all; it does not require satisfying the extreme any–occupation total disability standard, so Arthur satisfies the definition as long as he cannot perform his regular occupation and is not working in any capacity.

c. ✗ Incorrect. Falls into the Waiting Period Start Date trap: The waiting period must be calculated under policy terms from the date the insured satisfies the disability definition and remains continuously disabled, not retroactively from the initial diagnosis date of an underlying chronic condition.

d. ✓ Correct. Buy–sell disability buyout insurance in exam examples reduces coverage by 20% per year after age 60. When Arthur triggers the buyout at age 62, available coverage is significantly discounted from the original $800,000 face amount (reducing by 20% per year for two years, leaving coverage far below the $800,000 buyout valuation), creating a funding shortfall that illustrates why buy–sell agreements and coverage amounts must be reviewed regularly.

117′ answer a

a. ✓ Correct. The waiting period for disability buyout insurance commences from the date the insured satisfies the policy disability definition and ceases working (at age 61), never from the age–60 diagnosis date; after age 60, coverage reduces by 20% per year under exam examples; and because the definition requires being unable to perform regular occupation duties and not working at all, working part–time as a paid lecturer violates the zero–work composite threshold.

b. ✗ Incorrect. Falls into the Waiting Period Start Date and Overlooking Reduction trap: Working full–time fails the disability definition, so the waiting period cannot start from the diagnosis date; furthermore, benefit reductions begin after age 60.

c. ✗ Incorrect. Falls into the Disability Definition Level Confusion trap: Disability buyout coverage is stricter than pure own–occupation personal DI, requiring inability to perform one's regular occupation and not working at all, so engaging in other paid work prevents the buyout payout from triggering.

d. ✗ Incorrect. Falls into the Instalment Payout Mechanism Misunderstanding trap: Selecting 60 equal monthly instalments avoids draining massive lump–sum cash, using the buy–sell agreement to coordinate the recipient of insurance proceeds and instalment payouts to the exiting partner; it does not mean the surviving partner must shoulder five years of payments out of personal pocket.

118 answer b

a. ✗ Incorrect. Falls into the Statistics Memory Error trap: These figures are far lower than the 1985 actuarial table data cited in exam materials (approximately 40% for a single owner, approximately 62.5% for at least one of two co-owners, and an average duration of 3.2 years).

b. ✓ Correct. Under exam conventions citing the 1985 Commissioner's Disability Table: the probability of a 45-year-old owner experiencing a disability lasting longer than 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. (Note: Candidates must answer using these historical exam figures, but because modern Canadian consumer equivalents are unverified, they must never be presented as individual probability commitments in practice.)

c. ✗ Incorrect. Falls into the Single vs. Co-Owner Probability Inversion trap: 62.5% represents the probability that at least one of two co-owners suffers a disability, while the probability for a single owner under exam conventions is approximately 40%, with an average duration of 3.2 years rather than 5.0 years.

d. ✗ Incorrect. Falls into the Confusing Age Reduction with Disability Probability trap: 20% represents the annual coverage reduction percentage after age 60 in buyout insurance examples, not the disability probability for a 45-year-old business owner.

118′ answer d

a. ✗ Incorrect. Falls into the Misattributed Figures trap: 40% is the disability probability for a single 45-year-old owner, and 12 to 24 months represents the elimination period range for disability buyout insurance rather than the average disability duration.

b. ✗ Incorrect. Falls into the Number Confusion trap: 50% and 1 year (12 months) represent the high end of the key person shareholding cap range and the maximum benefit period respectively, not the co-owner disability probability and duration from the 1985 table.

c. ✗ Incorrect. Falls into the Number Confusion trap: 20% is the annual reduction rate after age 60 in buyout insurance and 60 months is the instalment payout period in modern buyout products, neither of which comes from the 1985 actuarial table.

d. ✓ Correct. According to the 1985 Commissioner's Disability Table cited in exam materials, the probability that at least one of two 45-year-old co-owners suffers a disability lasting over 90 days before age 65 is approximately 62.5% (approximately 40% for a single owner), with an average duration of 3.2 years. (Note: Candidates must answer using these exam figures, while practitioners use only the qualitative conclusion rather than making individual probability commitments.)

119 answer a

a. ✓ Correct. A grouped disability/CI plan refers to an employer purchasing individual DI or CI policies for multiple employees belonging to a defined class (such as all senior vice-presidents, rather than arbitrarily picking individual favourites); meanwhile, a Private Health Services Plan (PHSP) reimburses eligible medical expenses such as dental, vision, and prescription drugs, functioning neither as income replacement nor as business overhead.

b. ✗ Incorrect. Falls into the Violating Defined Class Underwriting Rules trap: A grouped disability/CI plan requires the employer to purchase coverage for an objective class of employees, and cannot be used to arbitrarily pick and choose specific individuals.

c. ✗ Incorrect. Falls into the Confusing PHSP with BOE trap: Reimbursing office lease payments and utility bills is the role of business overhead expense (BOE) insurance; a PHSP only reimburses health expenses, and the two cannot substitute for each other.

d. ✗ Incorrect. Falls into the Exaggerating HWT Transition Consequences trap: The CRA discontinued legacy administrative rules for Health and Welfare Trusts (HWT) after 2021; unconverted trusts are generally taxed under ordinary trust rules, rather than being seized by the government or declared illegal and forcibly dissolved.

119′ answer c

a. ✗ Incorrect. Falls into the Confusing PHSP with DI/BOE Functions trap: A Private Health Services Plan (PHSP) reimburses only routine medical expenses; it cannot replace personal DI to pay salaries, nor can it replace BOE to reimburse loan interest.

b. ✗ Incorrect. Falls into the Confusing Self–Employed Deduction Limits with Universal Contribution Caps trap: The $1,500 per adult and $750 per child under age 18 limits represent period–prorated deduction limits under Income Tax Act s.20.01 for specific self–employed categories, not a universal contribution cap across all PHSPs.

c. ✓ Correct. An employer purchasing individual DI/CI policies for a defined class of employees constitutes a grouped disability/CI plan; a Private Health Services Plan (PHSP) reimburses medical expenses outside provincial coverage such as dental, vision, and prescription drugs; and Employee Life and Health Trusts (ELHT) fall under Income Tax Act s.144.1, accommodating the transition from Health and Welfare Trusts (HWT) whose legacy administrative regime ended after 2021.

d. ✗ Incorrect. Falls into the Confusing Grouped Individual Plans with Traditional Group Policies trap: A grouped disability/CI plan procures multiple independent individual DI/CI policies rather than an insurer's traditional group master policy.

Chapter 18 answers and reasons

120 answer a

a. ✓ Correct. Insurable earned income for a self–employed individual is calculated based on net business income after deducting operating expenses ($72,000 – $12,000 = $60,000), while ongoing dividends are classified as unearned income and evaluated separately rather than directly added to boost insurable earned income; additionally, self–employed individuals who voluntarily register for Employment Insurance (EI) special benefits via MSCA must wait a full 12 months from the registration date to be eligible to claim benefits, and cannot claim prior to completing that 12–month period.

b. ✗ Incorrect. Falls into the double trap of Mistaking Gross Business Revenue for Insurable Income and Ignoring the 12–Month Registration Waiting Period: Operating expenses of $12,000 must first be deducted to determine insurable earned income; even if the prior year's net self–employment earnings exceed the threshold ($9,254), an individual registered for less than 12 months is not entitled to claim.

c. ✗ Incorrect. Falls into the trap of Adding Passive Dividends to Insurable Earned Income and Misunderstanding Withdrawal Rules: Passive dividends continue during disability and cannot be added directly to the insurable earned income base; furthermore, an agreement can only be withdrawn unconditionally within 60 days of voluntary registration, and once special benefits have been claimed, the agreement can never be terminated.

d. ✗ Incorrect. Falls into the Misunderstanding the Self–Employed EI Waiting Period Start Date trap: The 12–month waiting period for self–employed EI special benefits begins on the date the MSCA agreement takes effect (registration date), not from the date the business opened or the date of disability.

120′ answer c

a. ✗ Incorrect. Falls into the trap of Adding Rental Income to Insurable Earned Income and Misunderstanding the 60–Day Withdrawal Window: Ongoing rental income is not included in insurable earned income; moreover, as long as special benefits have never been claimed, registration can be unconditionally withdrawn within 60 days of registering, rather than becoming immediately permanent upon signing.

b. ✗ Incorrect. Falls into the Overlooking Dual Self–Employed Risk Exposures trap: Self–employed individuals face dual exposures of personal income disruption and continuing business overhead expenses, which often require two separate policies: individual disability insurance (DI) and business overhead expense (BOE) insurance.

c. ✓ Correct. Hannah's insurable earned income is her net business income of $60,000, with ongoing rental income cataloged separately under other financial resources; furthermore, because she registered for EI special benefits within the past 60 days and has never claimed benefits, she can unconditionally withdraw her agreement without owing premiums.

d. ✗ Incorrect. Falls into the Ignoring the 12–Month Registration Waiting Period trap: Even though her prior year's net self–employment earnings exceed the $9,254 threshold, she remains ineligible to claim benefits because she has been registered for less than 12 months.

121 answer b

a. ✗ Incorrect. Falls into the Conflating Income Approach Percentage with Statutory EI Percentage trap: 60% is an income approach or common group insurance replacement rate, whereas the statutory replacement rate for EI sickness benefits is 55%.

b. ✓ Correct. Under the 2022 LLQP exam benchmark, Employment Insurance (EI) sickness benefits have a maximum duration of 15 weeks, with an earnings replacement rate of 55% of average insurable weekly earnings (2022 weekly maximum around $638, former qualifying threshold of 420 hours). Note the dual–standard distinction: effective December 18, 2022, current federal legislation extended the maximum duration to 26 weeks (2026 weekly maximum $729, requiring 600 insurable hours), but candidates must answer 15 weeks when a question specifies the exam benchmark.

c. ✗ Incorrect. Falls into the Conflating Exam Benchmarks with Current Legislation and Confusing Replacement Rates trap: Although 26 weeks is the current statutory duration, the question stem explicitly asks for the standard exam benchmark (15 weeks), and 85% is a common group all–source maximum rather than the EI replacement rate (55%).

d. ✗ Incorrect. Falls into the Conflating EI Sickness Benefits with Provincial Workers' Compensation (WorkSafeBC) Rates trap: Approximately 90% of net earnings reflects BC workers' compensation benefit levels, while 52 weeks is the qualifying period length used to tally insurable hours rather than the benefit duration.

121′ answer a

a. ✓ Correct. Under the exam benchmark, Employment Insurance (EI) sickness benefits have a maximum duration of 15 weeks (current legislation has extended this to 26 weeks, but candidates answer according to the specified exam benchmark), but EI acts as second payor relative to group plans; when the employer's group coverage pays an amount equal to or greater than the EI 55% replacement rate and weekly maximum, actual EI disbursements may be zero, so EI must never be assumed to stack as extra income during profiling.

b. ✗ Incorrect. Falls into the Assuming EI Automatically Stacks on Top of Group Coverage trap: EI is the second payor to group plans, and benefits cannot be double–dipped when group coverage already caps what EI would pay.

c. ✗ Incorrect. Falls into the Inverting First Payor Rules trap: Between an employer group plan and EI, the group plan is the first payor and EI is the second payor.

d. ✗ Incorrect. Falls into the Deducting Employer STD Premium Reduction Requirements from Current 26–Week EI trap: Even though current EI sickness benefits are extended to 26 weeks, the minimum STD benefit duration required for an employer under the EI Premium Reduction Program remains 15 weeks; the two rules must be evaluated independently.

122 answer c

a. ✗ Incorrect. Falls into the Blindly Assuming Disability Benefits Are Tax–Free trap: A ratio of 80% ($3,600 divided by $4,500 after–tax salary) only occurs when the employee pays 100% of premiums to make the $3,600 benefit tax–free; in this scenario, the employer pays the premiums, so benefits are fully taxable.

b. ✗ Incorrect. Falls into the Net Versus Gross Income Confusion trap: While $2,700 is the correct after–tax benefit, the denominator for calculating the after–tax income replacement ratio must be pre–disability after–tax monthly income of $4,500 ($2,700 / $4,500 = 60%), rather than 50%.

c. ✓ Correct. Step one: determine tax status. Because the employer pays the premiums, group long–term disability (LTD) benefits are taxable. Step two: calculate figures. After–tax monthly earnings = $6,000 * (1 – 25%) = $4,500. Nominal LTD benefit = $6,000 * 60% = $3,600 (taxable). Net after–tax benefit = $3,600 * (1 – 25%) = $2,700. After–tax income replacement ratio = $2,700 / $4,500 = 60%.

d. ✗ Incorrect. Falls into the Conflating After–Tax Salary with All–Source Maximum trap: $4,500 is her pre–disability after–tax monthly salary rather than her disability benefit, and 85% is a common all–source maximum rather than her group LTD replacement rate.

122′ answer b

a. ✗ Incorrect. Falls into the Overlooking That Tax–Free Benefits Amplify After–Tax Replacement Ratios trap: When the employee pays 100% of the premiums, the benefit is received tax–free, and dividing it by after–tax net earnings of $4,500 yields an after–tax replacement ratio higher than the nominal 60%.

b. ✓ Correct. Because the employee pays 100% of the premiums, group LTD benefits are received tax–free, making the net take–home benefit $3,600; compared against his pre–disability after–tax monthly earnings of $4,500, the after–tax income replacement ratio is $3,600 / $4,500 = 80%.

c. ✗ Incorrect. Falls into the Conflating EI 55% Replacement Rate with Group LTD Percentage trap: Employee–paid group LTD is not restricted to the EI 55% replacement rate.

d. ✗ Incorrect. Falls into the Treating All–Source Maximum as an Automatic Top–Up Percentage trap: 85% is an all–source maximum designed to prevent overinsurance, and the insurer will not automatically increase a 60% benefit schedule to 85%.

123 answer d

a. ✗ Incorrect. Falls into the Overlooking Government Benefit Offsets trap: Adding the $3,000 tax–free LTD directly to $926.01 after–tax CPP–D overlooks that the group master contract will first deduct the pre–tax CPP–D amount of $1,234.68 dollar–for–dollar from the LTD benefit.

b. ✗ Incorrect. Falls into the Assuming Total After–Tax Income Remains Unchanged After Direct Offset trap: Although subtracting pre–tax CPP–D of $1,234.68 dollar–for–dollar from group LTD and adding nominal pre–tax CPP–D still totals $3,000 gross, what is offset is tax–free LTD and what replaces it is CPP–D subject to a 25% tax rate, so net take–home cash drops below $3,000 and the gap widens beyond Stage 1's $1,500.

c. ✗ Incorrect. Falls into the Calculating Remaining LTD While Omitting Net CPP–D trap: $1,765.32 is merely the remaining group LTD after deducting $1,234.68, forgetting to add back the $926.01 after–tax CPP–D Felix actually receives.

d. ✓ Correct. Step one: calculate the direct offset. Group LTD is reduced dollar–for–dollar by pre–tax CPP–D, leaving remaining tax–free LTD = $3,000 – $1,234.68 = $1,765.32. Step two: calculate net taxable CPP–D. $1,234.68 * (1 – 25%) = $926.01. Step three: sum total net cash flow. $1,765.32 + $926.01 = $2,691.33. Step four: calculate the monthly gap. Minimum living need $4,500 – $2,691.33 = $1,808.67 (which is larger than the $1,500 gap before CPP–D payments began).

123′ answer a

a. ✓ Correct. During Stage 1, Felix receives only the tax-free LTD benefit of $3,000/month, resulting in a monthly gap of $4,500 – $3,000 = $1,500; entering Stage 2 upon approval of taxable CPP-D and triggering the group direct offset, the monthly gap widens to $1,808.67. When conducting a gap analysis, the agent must present the net cash flow across each phase (elimination period, LTD onset, and government benefit approval) and size the individual coverage recommendation to cover the largest gap on the timeline.

b. ✗ Incorrect. Falls into the Assuming LTD Starts on Day One and Offsets CPP-D Before Approval trap: No LTD is payable during the elimination period, and CPP-D is not yet payable in Stage 1 (typically beginning in the fourth month after the month of disability), making the Stage 1 gap $1,500.

c. ✗ Incorrect. Falls into the Conflating Direct Offset with the 85% All-Source Maximum trap: Net take-home cash falling below an 85% all-source maximum does not permit ignoring the contractually mandated direct offset of CPP-D.

d. ✗ Incorrect. Falls into the Assuming Guaranteed Approval, Tax-Free Status, and Day-One Start Date for CPP-D trap: CPP-D is taxable income and begins in the fourth month following the month disability occurs, rather than bridging gaps tax-free from the date of diagnosis.

124 answer b

a. ✗ Incorrect. Falls into the Mismatching Calculation Methodologies and Financial Statements trap: When a client faces budget constraints, the agent should not rigidly insist on the income approach and cause the client to drop coverage; furthermore, this option completely reverses the functions of the net worth statement and cash flow statement.

b. ✓ Correct. When the income approach ($3,000/month) premium exceeds affordability, the agent should switch to the expense approach ($2,000/month) to secure baseline protection, paired with a future purchase option (FPO) rider to increase coverage as income grows; concurrently, the net worth statement verifies whether personal assets can weather the elimination period, while the cash flow statement verifies whether monthly discretionary funds exist to pay premiums.

c. ✗ Incorrect. Falls into the Tool Misuse (Using Net Worth Statement as a Substitute for Needs Calculation and Budgeting) trap: The net worth statement only evaluates whether the client can self-insure a short-term income disruption, and cannot replace needs analysis or cash flow budgeting.

d. ✗ Incorrect. A freelance translator is self-employed and must verify income via past two to three years of T1 tax returns and financial statements rather than an employee T4 slip; furthermore, gratuitously advising an RDSP withdrawal is inappropriate and would trigger grant repayment clawbacks.

124′ answer d

a. ✗ Incorrect. Falls into the Mismatching Calculation Methodologies and Financial Statements trap: Exactly reverses the distinct responsibilities of the cash flow statement and net worth statement.

b. ✗ Incorrect. A group benefits booklet only outlines existing group coverage terms and maximums, and cannot reflect the client's personal balance sheet reserves or monthly discretionary budget.

c. ✗ Incorrect. Marcus is a salaried employee rather than a business owner, and the income approach formula estimates theoretical replacement coverage rather than itemizing household expenses to trim.

d. ✓ Correct. The net worth statement (assets at fair market value minus liabilities) determines whether the client can self-insure through an income disruption (surviving the 120-day elimination period); the cash flow statement (tracking monthly net income minus expenses) reveals whether monthly discretionary income exists to pay premiums and which outlays can be trimmed.

125 answer a

a. ✓ Correct. Single client Liam has no second income buffer, so his $3,000/month calculated need cannot be compromised; while dual-earner client Noah sees his theoretical gap drop to $1,000/month due to his spouse's income, the exam benchmark cautions that spouse Maya may need to reduce hours or stop working to care for Noah if he becomes disabled, diminishing this theoretical cushion. Therefore, coverage must be structured with a caregiving cushion above the bare theoretical gap rather than mechanically purchasing only $1,000.

b. ✗ Incorrect. Falls into the Mechanically Adopting Theoretical Gaps and Fabricating Underwriting Caps trap: Insurers do not restrict dual-earner spouses to $1,000 in coverage, and mechanically copying $1,000 without a caregiving cushion is precisely the mistake highlighted in exam materials.

c. ✗ Incorrect. Falls into the Fabricating Government Benefit Advantages for Single Individuals trap: Single individuals have neither spousal income support nor double EI sickness benefit replacement rates (on the contrary, the EI Family Supplement is available only to low-income families with children under 18).

d. ✗ Incorrect. Falls into the Conflating Earned and Unearned Income trap: Spousal income is classified as unearned income (a household expense-sharing factor) in the client profile, and can never be added to Noah's own insurable earned income base to apply for higher individual coverage.

125′ answer c

a. ✗ Incorrect. Falls into the Overlooking the Impact of the Family Profile on Needs Calculation Denominators trap: The family block in the client profile directly dictates whether needs analysis requires full individual replacement or accounts for spousal income support.

b. ✗ Incorrect. A spouse's ongoing employment earnings do not trigger direct offset clauses in disability policies (direct offsets apply to statutory disability benefits such as CPP-D and workers' compensation).

c. ✓ Correct. Single client Priya has no secondary household income buffer if disabled and requires full coverage of $3,000/month under the income approach; dual-earner client Taran has partial spousal income support but must still maintain a caregiving cushion above the theoretical $1,000 gap in case her spouse takes time off work to care for her.

d. ✗ Incorrect. The EI Family Supplement requires dependent children under 18 receiving the Canada Child Benefit (CCB) and net family income of no more than $25,921, criteria that a single client without children does not satisfy.

126 answer c

a. ✗ Incorrect. Falls into the Equating Workers' Compensation Filing with CPP-D Approval trap: Provincial workers' compensation and federal CPP-D operate under completely different criteria; a short-term condition with expected quick recovery fails to meet CPP-D's prolonged requirement.

b. ✗ Incorrect. Falls into the Conflating Work-Related and Non-Work-Related Government Coverage Pathways trap: Assessing government benefits requires separating work-related from non-work-related pathways; work-related injuries are covered by provincial workers' compensation, rather than starting with EI sickness benefits.

c. ✓ Correct. First, distinguish work-related from non-work-related claims: an on-the-job injury falls under provincial workers' compensation (WorkSafeBC), which pays tax-free benefits benchmarked in exam materials at 80% to 90% of net earnings (BC currently pays approximately 90% of net calculated earnings up to the 2026 maximum wage rate of $127,500/year). Second, Canada Pension Plan disability (CPP-D) requires a disability to be both severe and prolonged; prolonged means indefinite duration or likely fatal, which a short-term curable back sprain does not satisfy.

d. ✗ Incorrect. Falls into the Fabricating MSP Dental Coverage and Misrepresenting Exam Scope trap: The exam materials make zero mentions of MSP, and BC MSP covers only medically required physician services; dental care is limited to rare surgical procedures in hospitals, not routine dental fillings.

126′ answer b

a. ✗ Incorrect. Falls into the Assuming CPP–D Starts on Accident Date, Is Tax–Free, and Guarantees Maximum Amounts trap: CPP–D is taxable income, typically begins four months after the month disability is determined, and its start date and benefit amount depend strictly on an official notice of determination.

b. ✓ Correct. Provincial workers' compensation and CPP–D are separate programs that can be applied for concurrently; however, during client profiling, unapproved CPP–D must be listed as pending, typically begins in the fourth month following the month of disability, and upon approval must be coordinated under plan offset and taxation rules rather than simply adding pre–tax figures into first–month cash flow.

c. ✗ Incorrect. Provincial workers' compensation benefits are tax–free, and claiming workers' compensation does not disqualify an individual from applying for other statutory benefits.

d. ✗ Incorrect. Although exam materials use generic terms like provincial agencies without explicitly naming WorkSafeBC, workers' compensation is explicitly included in the government benefits framework and functions as a direct offset in group master contracts, so it can never be ignored in gap analysis.

Chapter 19 answers and reasons

127 answer a

a. ✓ Correct. Under section 101 Condition 5, the statutory deadline for notice of claim is 30 days and for proof of claim is 90 days; if reporting within 30 days is not reasonably possible due to objective circumstances and notice is provided as soon as reasonably possible thereafter, late notice relief applies and the claim is not invalidated. Note the dual benchmark distinction: the exam benchmark caps late relief at no more than 6 months, whereas current BC statutory Condition 5 sets the ceiling at no later than 1 year; day 45 falls safely within both standards.

b. ✗ Incorrect. Falls into the Confusing the Three Claim Time Limits trap: Mistakenly treats the 30–day notice of claim deadline as an absolute bar causing automatic forfeiture, overlooking the late notice relief provisions of section 101 Condition 5.

c. ✗ Incorrect. Falls into the Confusing the Three Claim Time Limits trap: Conflates the 30–day notice of claim window with the 90–day proof of claim period; both statutory deadlines run concurrently from the date the claim arose and cannot be stacked sequentially.

d. ✗ Incorrect. Misattributes rules: A pro–rata benefit reduction is the remedy under the change of occupation clause (Condition 3) when an insured switches to a higher–risk occupation, and has no application to late notice of claim.

127′ answer c

a. ✗ Incorrect. Falls into the Confusing the Three Claim Time Limits trap: 30 days is the deadline for notice of claim rather than proof of claim, and missing the deadline does not cause absolute forfeiture when relief applies.

b. ✗ Incorrect. Conflates numbers: 60 days represents the ongoing claims payout frequency or non–income benefit payment window (payment of claims), not the 90–day proof of claim filing deadline.

c. ✓ Correct. Under section 101 Condition 5(1)(b), written proof of claim must be submitted within 90 days from the date the claim arose (running concurrently with the 30–day notice period); if doing so on time is not reasonably possible and proof is furnished as soon as reasonably possible, late notice relief applies. The exam benchmark caps this relief at up to 6 months, whereas current BC legislation provides up to 1 year.

d. ✗ Incorrect. Conflates insurer obligations with insured duties: 15 days is the insurer's deadline to supply claim forms after receiving notice (Condition 6) or the registered mail notice window for policy termination (Condition 4), not the insured's proof deadline.

128 answer b

a. ✗ Incorrect. Falls into the Assuming Claim Denial for High–Risk Change of Occupation trap: Under section 101 Condition 3 (change of occupation clause), switching to a higher–risk occupation after issuance does not result in outright claim denial or contract voidance.

b. ✓ Correct. Under the change of occupation clause in section 101 Condition 3, when an insured suffers a loss after engaging in a higher–risk occupation, the benefit amount is adjusted pro–rata to what the original premium paid would have purchased under the new occupational rate class, rather than denied outright.

c. ✗ Incorrect. Conflates the two–year incontestability period (s.112, which governs misrepresentation and material disclosure at issue or reinstatement) with ongoing occupational changes during the policy term (change of occupation clause, Condition 3).

d. ✗ Incorrect. Fabricates rules and conflates with grace period: The statutory mechanism under Condition 3 adjusts the benefit payout pro–rata based on the premium paid relative to the new classification, rather than demanding retroactive premium back–payments.

128′ answer a

a. ✓ Correct. Under section 101 Condition 3 (change of occupation clause), when an insured transitions to a higher–risk occupation, the insurer pays the reduced benefit that the actual premium paid would have purchased under the new rate schedule, rather than denying the claim.

b. ✗ Incorrect. Falls into the Assuming Claim Denial for High–Risk Change of Occupation trap: Condition 3 mandates a pro–rata benefit reduction based on the applicable rate tables, not policy termination or claim denial.

c. ✗ Incorrect. Conflates the elimination period with the change of occupation clause: Condition 3 adjusts the monthly benefit amount pro–rata, but does not alter or extend the elimination period.

d. ✗ Incorrect. Condition 3 applies a pro–rata adjustment mechanism based on the premium paid and the new risk classification, rather than denying claims based on where or how the injury occurred.

129 answer c

a. ✗ Incorrect. Extending the elimination period requires the client to self–fund the initial 90–day waiting window with personal emergency reserves, but if the policy remains guaranteed renewable, the insurer cannot unilaterally cancel the coverage.

b. ✗ Incorrect. Shortening the benefit period leaves the client exposed to income loss if disability extends beyond 5 years, but under a non–cancellable policy, the insurer cannot unilaterally terminate coverage during the policy term.

c. ✓ Correct. Among the four premium adjustment levers, converting guaranteed renewable to cancellable coverage carries the highest sacrifice: the insurer regains the unilateral right under section 101 Condition 4 to cancel or refuse renewal with 15 days notice by registered mail or 5 days personal delivery, potentially stripping coverage away after health deteriorates or a claim occurs.

d. ✗ Incorrect. Falls into the reverse misunderstanding of renewability tiers: Moving from non–cancellable to guaranteed renewable allows the insurer to adjust premiums en masse for an entire rate class, but the insurer still cannot unilaterally terminate an individual policy.

129′ answer b

a. ✗ Incorrect. Conflates guaranteed renewable with cancellable contracts: A guaranteed renewable policy legally restricts the insurer from unilaterally terminating or refusing renewal under Condition 4 during the stated term.
b. ✓ Correct. Avoids the Equating Guaranteed Renewable with Non-Cancellable trap: Under a guaranteed renewable policy, the insurer cannot unilaterally cancel the contract or single out an individual for an increase, but it may adjust premiums en masse for an entire occupational rate class; only a non-cancellable contract completely locks both premiums and benefits.
c. ✗ Incorrect. Falls into the classic Equating Guaranteed Renewable with Non-Cancellable trap: Only a non-cancellable policy fully locks premiums and provisions through maturity; guaranteed renewable permits class-wide rate adjustments.
d. ✗ Incorrect. Violates the fundamental definition of guaranteed renewability: The insurer can never selectively single out an individual policyholder for a premium increase, but must apply adjustments across the entire rating class.

130 answer d

a. ✗ Incorrect. Misattributes statutory numbers: 30 days and 90 days are the insured's deadlines for submitting notice of claim and proof of claim respectively, not the insurer's timelines for providing forms or paying benefits.
b. ✗ Incorrect. Falls into the Expecting Deferred First Claim Payment trap: 5 days is the personal delivery timeframe for insurer termination under Condition 4, and the insurer cannot withhold the initial loss-of-income payment until the disability ends or the claim is closed.
c. ✗ Incorrect. Inverts the statutory payment schedule and conflates Condition 8 with Condition 9: Payout within 60 days of proof applies to non-income benefits (Condition 8), whereas loss-of-income benefits require the first payment within 30 days and ongoing payments at least every 60 days (Condition 9).
d. ✓ Correct. Under section 101 Condition 6, the insurer must provide proof of claim forms within 15 days of receiving notice; under Condition 9, the initial loss-of-income payment must be made within 30 days of receiving proof, with ongoing payments at least every 60 days during continuous liability upon receipt of continuing proof.

130′ answer a

a. ✓ Correct. Under section 101 Condition 4 (termination of insurance), an insurer unilaterally terminating a cancellable individual A&S policy must give at least 15 days notice by registered mail (running from the date the letter or notification arrives at the insured's postal address) or 5 days notice personally delivered; the insured may terminate at any time.
b. ✗ Incorrect. Conflates the statutory grace period (30 days, s.106) with policy termination notice periods (15 days registered mail or 5 days personal delivery, Condition 4).
c. ✗ Incorrect. Conflates the claims payment schedule (30 days initial, 60 days ongoing, Condition 9) with policy termination notice periods (15 days registered mail or 5 days personal delivery, Condition 4).
d. ✗ Incorrect. Conflates the 90-day proof of claim filing period (Condition 5(1)(b)) with policy termination notice requirements (Condition 4).

131 answer a

a. ✓ Correct. Regarding the group conversion window, exam materials contain conflicting references between chapter 2 (30 days) and chapter 7 (31 days), and group A&S rules cannot blindly adopt group life insurance conventions; candidates should follow the specific number provided in the exam stem, while in practice advisors must verify the client's actual group contract documents, using the more conservative shorter deadline if documents are unavailable.

b. ✗ Incorrect. Dual error: Section 101 statutory conditions explicitly exclude group and creditor group policies, and 90 days is the individual proof of claim deadline, not a group conversion window.

c. ✗ Incorrect. Falls into the Blindly Applying Group Conversion Days trap: Group life and group A&S are governed by separate contract provisions; an advisor cannot assume the 31-day life window automatically applies to group disability without verifying the specific plan text.

d. ✗ Incorrect. Misattributes rules: The 6-month exam benchmark and 1-year statutory limit apply to late notice relief for individual claims, having no bearing on group conversion rights.

131′ answer d

a. ✗ Incorrect. Section 101 statutory conditions explicitly exclude group insurance, and 90 days represents the deadline for submitting proof of claim.

b. ✗ Incorrect. Conflates the two-year incontestability period or statutory life reinstatement windows with group conversion rights.

c. ✗ Incorrect. Conflates the 60-day payment timeframe for non-income claims (payment of claims) with group conversion rights.

d. ✓ Correct. The exam curriculum contains conflicting references to 30 days and 31 days for group A&S conversion; in practice, the advisor must check the client's specific group plan contract or HR benefits summary rather than blindly assuming a 31-day window, urging the client to apply within the more conservative timeframe to avoid forfeiting guaranteed issue rights.

132 answer b

a. ✗ Incorrect. Falls into the Transposing Life Insurance Issue and Reinstatement Rules trap: The default life insurance formation rule under BC section 39 (requiring delivery, initial premium payment, and unchanged insurability) cannot be directly applied to A&S policies.

b. ✓ Correct. Under A&S legislation section 106(1), 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); this contrasts sharply with life insurance section 39, which requires delivery, initial payment, and unchanged insurability. Renewal premiums thereafter receive a statutory grace period of at least 30 days.

c. ✗ Incorrect. Conflates the 10-day right of examination with policy formation rules: The client's statutory cancellation right cannot be inverted by the insurer to disclaim binding coverage that has legally attached upon delivery.

d. ✗ Incorrect. Falls into the Transposing Life Insurance Issue and Reinstatement Rules trap: Conflates initial policy delivery with post-lapse reinstatement, and improperly imports statutory life reinstatement provisions under section 57.

132′ answer c

a. ✗ Incorrect. Falls into the Transposing Life Insurance Issue and Reinstatement Rules trap: The 2-year statutory reinstatement right under section 57 is a life insurance rule; Part 4 of the Insurance Act provides no equivalent universal statutory reinstatement window for A&S.

b. ✗ Incorrect. Conflates numbers: 90 days is the statutory deadline for submitting proof of claim, having no relation to policy reinstatement following a premium lapse.

c. ✓ Correct. Part 4 contains no uniform statutory reinstatement window like section 57 in life insurance; reinstatement terms depend entirely on the contract provisions. However, section 113 mandates that disclosures upon reinstatement and the two-year incontestability clock (running afresh from reinstatement) remain strictly governed by statute.

d. ✗ Incorrect. While coverage lapses after the 30-day grace period expires (s.106), the policy may still be reinstated if contractual conditions are met; statute does not prohibit reinstatement.

133 answer b

a. ✗ Incorrect. Dual error: Reverses the meanings of own-occupation and any-occupation definitions, and mistakenly assumes the 90-day elimination period is deducted from the 5-year benefit period; elimination and benefit periods do not offset each other.

b. ✓ Correct. Under an own-occupation definition, the insured qualifies for total disability benefits if unable to perform the essential duties of their regular surgical specialty, even if working in another occupation (potentially earning equal or higher income); additionally, the elimination period and benefit period do not offset, ensuring the full 5-year benefit period remains available after the 90-day waiting period ends.

c. ✗ Incorrect. Fabricates rules: Selecting an own-occupation definition does not waive the two-year statutory incontestability period under section 112, nor does a 90-day elimination period convert a 5-year benefit period into coverage to age 65.

d. ✗ Incorrect. Completely backwards: Own-occupation is the most expensive definition, not the cheapest, and a 90-day elimination period does not replace or modify the 30-day statutory notice of claim deadline under Condition 5.

133′ answer a

a. ✓ Correct. A longer elimination period significantly reduces policy premiums; because Kenji has employer-provided group STD covering the first 120 days, his advisor can align the individual policy with a 120-day elimination period to lower costs without creating an unhedged income gap.

b. ✗ Incorrect. Contradicts sound recommendation trade-offs: A short 30-day elimination period is costly, wastes premium budget, and produces redundant coverage alongside the employer's existing STD plan.

c. ✗ Incorrect. Group STD only covers short-term illness, meaning the client specifically requires a long benefit period (e.g., to age 65) for catastrophic disability protection; furthermore, switching to cancellable allows the insurer to cancel coverage unilaterally.

d. ✗ Incorrect. Violates step 5 of the six recommendation steps: Regardless of existing group coverage, an advisor recommending an individual A&S policy must always document a written reason-why recommendation record confirmed by the client.

Chapter 20 answers and reasons

134 answer b

a. ✗ Incorrect. A group of 40 employees already exceeds the 25–employee pooled experience threshold, and the law does not bar a 40–person group from using refund accounting or ASO. Remaining permanently in non–refund accounting fails to meet the employer's goals of sharing in surpluses and progressively increasing flexibility.

b. ✓ Correct. Although a 40–person group has healthy cash flow and stable claims, its size remains relatively small and subject to claims volatility. Using refund accounting (retention accounting) as a transitional step to share volatility with the insurer and receive partial premium refunds when claims are lower than expected –– before later evaluating a move to Administrative Services Only (ASO) with stop–loss insurance –– best aligns with the risk spectrum of group funding methods.

c. ✗ Incorrect. Although ASO allows the employer to retain 100% of any surplus, the employer must absorb all claims fluctuation risk itself rather than carrying zero risk (Trap: Misunderstanding ASO as unmanaged self–insurance or ignoring risk volatility).

d. ✗ Incorrect. An Employee Assistance Plan (EAP) provides counselling for mental health, addiction, family, and legal or financial issues; it does not reimburse specialty prescription drug expenses.

134′ answer a

a. ✓ Correct. Under non–refund accounting (fully insured), the insurer assumes all claims risk and absorbs deficits, with worse–than–expected claims reflected only in subsequent renewal rate adjustments. This is ideal for employers with tight cash flow, risk aversion, and a need for budget certainty.

b. ✗ Incorrect. Refund accounting requires the employer to share in claims volatility and potential deficits, making it unsuitable for a small start–up with tight cash flow.

c. ✗ Incorrect. Under ASO, the employer must directly fund every incurred claim and bear the risk of volatility, which a small business owner with tight monthly cash flow cannot absorb (Trap: Misunderstanding ASO as unmanaged self–insurance or ignoring risk volatility).

d. ✗ Incorrect. A new group with fewer than 25 employees and zero claims history has zero credibility and must be pooled under manual rating; furthermore, experience rating is a pricing method, not a funding method.

135 answer c

a. ✗ Incorrect. The group's credibility is only 30%, not 100%, so the pure experience rate of $45 cannot be used directly.

b. ✗ Incorrect. This reverses the credibility weighting: 30% is the weight for the experience rate, while 70% is the weight for the manual rate (Trap: Reversing credibility weighting in blended rating).

c. ✓ Correct. Blended rate = (credibility * experience rate) + ((1 – credibility) * manual rate) = (0.3 * $45) + (0.7 * $60) = $13.50 + $42.00 = $55.50.

d. ✗ Incorrect. Whenever credibility exceeds zero, experience and manual rates are weighted proportionally; the formula defaults entirely to the manual rate only when there is zero claims history (credibility = 0).

135′ answer d

a. ✗ Incorrect. This completely reverses the actuarial logic: a group with fewer than 25 employees and no claims history lacks statistical significance and has the lowest credibility (zero), whereas a large employer with low turnover and a long claims history has high credibility (Trap: Reversing credibility weighting in blended rating).

b. ✗ Incorrect. Credibility is not a fixed constant; it is assessed dynamically based on group size, turnover rate, and years of verifiable claims data.

c. ✗ Incorrect. Having zero credibility does not mean a group cannot obtain group insurance; it simply means Firm X will be priced using manual rating within a pooled experience group.

d. ✓ Correct. A new, small group with no claims history has zero credibility, causing the blended formula to default entirely to manual rating. Conversely, Firm Y –– with its large size, low annual turnover (5–10%), and long claims history –– receives a high credibility rating, giving its experience rate primary weighting.

136 answer a

a. ✓ Correct. When an employer contributes to periodic wage-loss replacement plans (STD/LTD), under ITA s. 6(1)(f) the entire benefit is subject to tax, but the employee can deduct cumulative unapplied employee contributions from prior years: $9,600 – $3,600 = $6,000.

b. ✗ Incorrect. The premium-sharing split (50%) only dictates how much premium the employee paid each year; it cannot be applied directly to split the benefit payout into taxable and non-taxable percentages (Trap: Treating premium sharing percentage as taxable benefit percentage).

c. ✗ Incorrect. As long as the employer pays any portion of the premium for a qualifying group disability plan (i.e., it is not a 100% employee-paid plan), the benefits are not entirely tax-free; instead, benefits are taxable after deducting unapplied cumulative employee contributions.

d. ✗ Incorrect. Employer contributions to a qualifying group STD/LTD plan do not create a taxable benefit when paid, and employee contributions are deducted from taxable benefits when claims are received.

136′ answer c

a. ✗ Incorrect. Group disability benefits are never split into taxable amounts based on a 50% premium sharing ratio (Trap: Treating premium sharing percentage as taxable benefit percentage).

b. ✗ Incorrect. The $3,600 in cumulative employee contributions that was already used to offset benefits in a prior year cannot be deducted again in subsequent years.

c. ✓ Correct. Under ITA s. 6(1)(f), only cumulative employee contributions that have not yet been used to offset prior benefits may be deducted. Because the $3,600 was fully exhausted last year and no new premiums were paid this year, the entire $9,600 is taxable income this year.

d. ✗ Incorrect. The Income Tax Act does not contain any rule capping cumulative taxable benefits at historical premium contribution amounts.

137 answer d

a. ✗ Incorrect. The primary payer for dependent children is determined strictly by which parent's birthday falls earlier in the calendar year (the birthday rule), regardless of which plan offers a higher reimbursement percentage (Trap: Misjudging birthday rule criteria and omitting the lesser-of comparison for secondary payer).

b. ✗ Incorrect. The secondary payer pays the lesser of what it would have paid as primary ($600) and the unpaid balance left by the primary plan ($120); total reimbursement under COB can never exceed 100% of actual eligible expenses (Trap: Misjudging birthday rule criteria and omitting the lesser-of comparison for secondary payer).

c. ✗ Incorrect. Co-ordination of benefits (COB) follows a sequential primary-then-secondary top-up process, not an equal 50/50 split between insurers.

d. ✓ Correct. Under the birthday rule, Liam's birthday (March 15) falls earlier in the calendar year than Elena's (July 2), making Liam's plan primary. Liam's plan pays 80% * $600 = $480, leaving an unpaid balance of $120. Elena's plan, as secondary payer, pays the lesser of what it would have paid as primary (100% * $600 = $600) and the unpaid balance ($120), paying $120 and leaving an out-of-pocket family cost of $0.

137′ answer b

a. ✗ Incorrect. The birthday rule applies only to claims for dependent children; an employee's own medical or dental expenses must always be submitted first to their own employer's plan (Trap: Misjudging birthday rule criteria and omitting the lesser-of comparison for secondary payer).

b. ✓ Correct. Under standard COB guidelines, a plan member's own expenses must be submitted first to their own plan (Hannah's plan), which pays 80% * $600 = $480. Her spouse's plan (Noah's plan) acts as secondary payer, paying the lesser of what it would have paid as primary ($600) and the unpaid balance ($120), reimbursing $120.

c. ✗ Incorrect. In dual-income families, a claimant cannot bypass their own plan to claim under a spouse's plan as primary; claims must be submitted to the employee's own plan first before the spouse's plan tops up.

d. ✗ Incorrect. The spouse's plan acts as secondary payer and can top up the $120 balance left unpaid by the primary plan.

138 answer a

a. ✓ Correct. An employer STD plan must be equal to or greater than the EI sickness benefit benchmark to qualify for an ESDC premium reduction: the minimum duration requirement is at least 15 weeks (the exam benchmark is 15 weeks; even though current law extended EI sickness to 26 weeks, ESDC rules still maintain the 15–week minimum duration for employer STD plans), with an income replacement rate of at least 55% capped at no less than the annual EI weekly maximum.

b. ✗ Incorrect. A 70–75% benefit is merely a common industry design rather than the ESDC statutory minimum (55%), and the ESDC minimum duration requirement remains 15 weeks; plans providing 15 weeks are not disqualified simply because current EI sickness duration was extended to 26 weeks (Trap: Confusing extended EI duration with the ESDC reduction threshold).

c. ✗ Incorrect. Covering only the 1–week waiting period falls far short of the ESDC requirement of at least 15 weeks of benefits at a minimum 55% replacement rate.

d. ✗ Incorrect. ESDC premium reduction evaluates STD benefit levels, elimination periods, employee participation, and premium savings sharing; it does not mandate ASO funding or restrict eligibility to groups under 25 employees.

138′ answer c

a. ✗ Incorrect. A 3–month period is a typical group plan qualification period and 30–60 days is a typical enrolment window; neither represents the duration of EI sickness benefits.

b. ✗ Incorrect. This reverses the benchmark figures: the traditional exam benchmark is 15 weeks (capped at $638 per week), whereas current law has extended benefits to 26 weeks (capped at $729 per week in 2026) (Trap: Confusing extended EI duration with the ESDC reduction threshold).

c. ✓ Correct. The traditional exam benchmark remains 15 weeks (after a 1–week waiting period) at a 55% replacement rate capped at $638 per week. Under current legislation following Bill C–30, benefits are extended to 26 weeks (capped at $729 per week in 2026); unless an exam question stem specifically cites updated statutory figures, candidates should answer using the 15–week benchmark.

d. ✗ Incorrect. A 50–60% replacement rate is a common example for long–term disability (LTD), and 4 years was the claims history duration used in the blended rating example.

139 answer b

a. ✗ Incorrect. This is the exact opposite of the tax rules: employer contributions to a qualifying PHSP (health and dental) are generally non–taxable at the federal level, whereas employer–paid group term life and scheduled AD&D premiums constitute a taxable benefit to employees.

b. ✓ Correct. Tax rules must be evaluated by specific benefit type: employer–paid premiums for group term life and scheduled AD&D generally constitute an annual taxable benefit to employees (while lump–sum death or dismemberment benefits are generally tax–free), whereas employer premiums for qualifying PHSP health and dental coverage do not create a federal taxable benefit (provincial rules in Quebec differ).

c. ✗ Incorrect. That is the tax logic for employer–supported periodic STD/LTD wage–loss replacement plans, which cannot be applied to life insurance, AD&D, or PHSP health and dental reimbursements (Trap: Treating premium sharing percentage as taxable benefit percentage or misapplying tax rules across benefit types).

d. ✗ Incorrect. The Income Tax Act assesses taxable benefits according to specific coverage categories; there is no universal rule taxing 50% of group premiums.

139′ answer a

a. ✓ Correct. Qualifying group STD/LTD wage-loss replacement plans generate no taxable benefit when employer premiums are paid, but periodic benefits received by an employee are taxable under ITA s. 6(1)(f) (because the employer paid 100% of premiums and employee cumulative contributions are zero, the benefits are 100% taxable).

b. ✗ Incorrect. Although employer-paid group term life premiums constitute an annual taxable benefit, the capital death benefit paid to beneficiaries is generally non-taxable.

c. ✗ Incorrect. Reimbursements received under a qualifying private health services plan (PHSP) for health and dental expenses are generally non-taxable to the employee.

d. ✗ Incorrect. Even though the plan sponsor is the policyholder, periodic income replacement benefits from employer-supported STD/LTD plans must be included in the employee's taxable income under tax law.

140 answer c

a. ✗ Incorrect. The master contract is executed between the employer and the insurer and does not require individual signatures from every employee; furthermore, claims adjudication and payment are not broker duties.

b. ✗ Incorrect. Although employees do not sign the master contract, under BC Insurance Act s. 96 they have statutory rights to obtain policy copies (with s. 99 governing certificates and s. 116 governing replacement duties), and brokers must fulfill ongoing service and complaint-handling obligations.

c. ✓ Correct. The master contract is executed between the plan sponsor (the employer) and the insurer, while employees receive only a benefit booklet; the employer may change carriers (though members retain statutory rights under BC Insurance Act s. 96 for policy copies, s. 99 for certificates, and s. 116 for replacement protection). Claims adjudication and payment are handled by the insurer or third-party administrator (TPA), while the broker assists with ongoing service and complaint referral.

d. ✗ Incorrect. A request for quotation (RFQ) is the process during the quoting stage where a broker solicits competing quotes from insurers; ESDC does not adjudicate private group dental claims.

140′ answer b

a. ✗ Incorrect. The quoting stage does not require collecting employees' personal tax returns or LTD contribution histories from unrelated prior employers.

b. ✓ Correct. Prior to designing a plan and issuing a request for quotation (RFQ), the broker must collect group makeup details (headcount, age and gender distribution, turnover rate), industry classification, an employee data sheet (salaries, occupational classes, dependant details), and existing plan provisions along with historical claims experience if replacing a plan.

c. ✗ Incorrect. Employees do not sign the master contract, and spousal birthdays are verified only when coordinating benefits (COB) for dependent children at the time of a claim.

d. ✗ Incorrect. Group life, STD, and LTD coverages typically base benefit schedules on salary multiples or job classifications, requiring an employee data sheet; furthermore, there is no verified standard 33% ASO discount rate (Trap: Misunderstanding ASO as unmanaged self-insurance or ignoring risk volatility).

Chapter 21 answers and reasons

141 answer a

a. ✓ Correct. Compound interest future value FV = $10,000 * (1.06)^20 ≈ $32,071, whereas simple interest future value = $10,000 * (1 + 6% * 20) = $22,000. The difference is approximately $10,071, arising entirely from interest earning interest.

b. ✗ Incorrect. The $12,000 figure is the total interest generated by simple interest over 20 years ($10,000 * 6% * 20), not the excess accumulated by compounding over simple interest.

c. ✗ Incorrect. The $22,000 figure is the total future value (principal plus interest) of the simple interest account after 20 years, mistakenly confusing the total simple interest balance with the difference between compounding and simple interest.

d. ✗ Incorrect. The $32,071 figure is the total future value (FV) of the compounding account after 20 years, without subtracting the simple interest account future value of $22,000.

141′ answer c

a. ✗ Incorrect. This is calculated using the simple interest formula $10,000 * (1 + 6% * 20) = $22,000, omitting the compounding effect of interest reinvested into principal to generate further earnings.

b. ✗ Incorrect. The $10,071 figure is the net difference between the 20-year compound future value and the simple interest future value, not the total future value (FV) of the account at maturity.

c. ✓ Correct. According to the compound interest future value formula (FV = PV * (1 + r)^n), $10,000 * (1.06)^20 ≈ $10,000 * 3.207 ≈ $32,071.

d. ✗ Incorrect. This results from misapplying the Rule of 72 (72 / 6 = 12 years to double to $20,000) and roughly extrapolating a fourfold increase over 24 years, whereas exact compound future value calculations require using FV = PV * (1 + r)^n.

142 answer b

a. ✗ Incorrect. Falls into the TFSA same-year re-contribution over-contribution trap; withdrawn TFSA room does not restore immediately in the same year and is only added back to available room on January 1 of the following calendar year.

b. ✓ Correct. Because Nadia has no remaining Tax-Free Savings Account (TFSA) contribution room in the current year and the withdrawn room is not restored until January 1 of the following year, re-contributing $5,000 in the same calendar year constitutes an over-contribution subject to a 1% per month penalty tax under the Income Tax Act.

c. ✗ Incorrect. Confuses different account rules: the $2,000 lifetime over-contribution buffer applies to Registered Retirement Savings Plans (RRSPs), whereas TFSAs provide no penalty-free over-contribution cushion.

d. ✗ Incorrect. Qualifying TFSA withdrawals remain tax-free; an over-contribution triggers a 1% per month penalty tax on the excess amount, but does not retroactively make previous withdrawals taxable.

142′ answer a

a. ✓ Correct. Amounts withdrawn from a Tax-Free Savings Account (TFSA) in a given calendar year are only added back to the individual's available contribution room on January 1 of the following calendar year.

b. ✗ Incorrect. Falls into the TFSA same-year re-contribution over-contribution trap; when no contribution room remains in the current year, re-contributing within the same year creates an over-contribution subject to a 1% per month penalty tax.

c. ✗ Incorrect. Confuses RRSP deadlines with TFSA rules; TFSA contribution room is restored on a calendar-year basis on January 1, not matching the early March RRSP contribution deadline.

d. ✗ Incorrect. Confuses RRSP with TFSA room mechanics; RRSP withdrawals permanently lose contribution room, whereas TFSA withdrawals are fully restored on January 1 of the following calendar year.

143 answer c

a. ✗ Incorrect. Falls into the RRSP contribution base year and dollar limit omission trap: $11,700 is improperly calculated using current-year income ($65,000 * 18%), whereas new RRSP room must be based on the previous year's earned income.

b. ✗ Incorrect. Age 65 is a common retirement age, but the statutory maturity deadline for an individual RRSP is December 31 of the year the plan holder turns 71, not age 65.

c. ✓ Correct. New Registered Retirement Savings Plan (RRSP) contribution room is 18% of the previous year's earned income ($40,000 * 18% = $7,200, which is below the annual dollar limit), and 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).

d. ✗ Incorrect. Double error: improperly uses current-year income to calculate 18%, and confuses the RDSP maximum contribution age (December 31 of the year turning 59) with the RRSP maturity age.

143′ answer b

a. ✗ Incorrect. RRSP funds cannot be transferred directly into a TFSA on a tax-deferred basis; withdrawing funds from an RRSP to deposit into a TFSA causes the entire withdrawal to be included in taxable income for the current year.

b. ✓ Correct. An individual RRSP must mature by December 31 of the year the owner turns 71; compliant options include converting directly into a Registered Retirement Income Fund (RRIF) or purchasing an eligible annuity (both maintaining tax deferral with payments taxed as received), or taking a lump-sum withdrawal (fully taxable in that year).

c. ✗ Incorrect. An individual RRSP must be closed or converted by December 31 of the year turning 71; a plan holder cannot keep their own RRSP open merely because they continue working.

d. ✗ Incorrect. Maturity options for an RRSP do not include tax-free transfers into an RESP, as these registered plans serve entirely different legislative purposes.

144 answer b

a. ✗ Incorrect. Falls into the segregated fund regulation and protection mismatch trap: CIRO (referred to as IIROC/MFDA in the exam manual) and the Canadian Investor Protection Fund (CIPF) oversee securities and mutual fund dealers, not segregated funds issued by insurance companies.

b. ✓ Correct. A segregated fund (individual variable insurance contract or IVIC) is a life insurance contract whose sale is regulated by provincial insurance regulatory authorities (such as the Insurance Council of BC and BCFSA in British Columbia), and policyholders are protected against insurer insolvency by Assuris.

c. ✗ Incorrect. Double error: Canada Deposit Insurance Corporation (CDIC) protects only eligible deposits at member institutions (such as GICs, up to $100,000), and no protection organization indemnifies against market downturn losses.

d. ✗ Incorrect. Assuris protects policyholder contractual benefits only in the event of life insurer insolvency, never reimbursing normal market decline losses.

144′ answer d

a. ✗ Incorrect. Falls into the insolvency-versus-market-loss trap: coverage limits apply only to missing client property caused by dealer insolvency, never to market decline losses.

b. ✗ Incorrect. Confuses protection concepts: investor protection funds do not guarantee any percentage of invested principal; normal market risk is borne entirely by the investor.

c. ✗ Incorrect. CDIC protects only eligible deposits (such as savings accounts and GICs), does not cover mutual funds, and likewise does not reimburse market value declines.

d. ✓ Correct. Whether CDIC, CIPF (listed separately as CIPF and IPC in the exam manual), or Assuris, all protect solely against member insolvency and provide zero compensation for market value declines.

145 answer b

a. ✗ Incorrect. Completely reverses both FHSA benefits: FHSA contributions are tax–deductible (like an RRSP), and qualifying home purchase withdrawals are tax–free with no repayment obligation like the HBP.

b. ✓ Correct. The First Home Savings Account (FHSA, launched in 2023 and not included in the 2022 exam manual) combines tax–deductible contributions with tax–free qualifying home purchase withdrawals ($8,000 annual limit, $40,000 lifetime limit); in contrast, the RRSP HBP is essentially borrowing from retirement savings and must be repaid over time, or unrepaid amounts become taxable income.

c. ✗ Incorrect. Common misconception: mistakenly treating the FHSA, RRSP HBP, and TFSA as mutually exclusive; in reality, all three can be combined and used together for a first home purchase.

d. ✗ Incorrect. RRSPs have a definite annual contribution limit (the lesser of 18% of the previous year's earned income and the dollar limit), and using an RRSP for a short–term three–year home purchase imposes an HBP long–term repayment obligation, unlike an FHSA which allows tax–free withdrawals without repayment.

145′ answer d

a. ✗ Incorrect. Confuses RRSPs and TFSAs with special grant–matching accounts: contributions to both RESPs and RDSPs are made with after–tax dollars (non–deductible), and withdrawals of government grants and investment growth are not tax–free.

b. ✗ Incorrect. On withdrawal, the return of original principal contributions is tax–free, while accumulated earnings and government grants are included in the taxable income of the beneficiary (the student or disabled beneficiary), not the contributor.

c. ✗ Incorrect. The $50,000 (RESP) and $200,000 (RDSP) limits are lifetime caps rather than annual limits; neither plan has an annual contribution ceiling, and grants and earnings grow tax–deferred until withdrawn.

d. ✓ Correct. Contributions to RESPs and RDSPs are after–tax and non–deductible; on withdrawal, contribution principal returns tax–free, while government grants (CESG/CDSG, etc.) and accumulated investment growth (such as RESP EAPs and taxable RDSP payments) are taxed as income in the hands of the beneficiary.

146 answer c

a. ✗ Incorrect. Falls into the high net worth equating to high risk capacity trap: a net worth statement only shows asset quantity, and an agent cannot deduce high objective risk capacity or an absence of insurance needs solely from high net worth.

b. ✗ Incorrect. Violates client profiling before product selection and time horizon matching: capital needed in the short term (3 years or less) must not be allocated to volatile equity funds, even if the client subjectively feels comfortable with market swings.

c. ✓ Correct. KYC rules require documenting risk tolerance, risk capacity, and risk perception separately; holding all assets in GICs and savings accounts often reflects low practical capacity, and capital needed within two years (a short–term horizon of 3 years or less) is unsuitable for high–volatility equity funds.

d. ✗ Incorrect. In the four–dimensional investment matrix, annuities offer very low liquidity (once payouts begin they are generally irrevocable), making them entirely unsuitable for a lump–sum cash requirement needed in two years.

146′ answer a

a. ✓ Correct. In non-registered accounts, interest income is 100% taxable at the marginal rate, the capital gains inclusion rate remains 50% (the 2024—2025 proposal to raise it to two-thirds was withdrawn), and due to interest rate risk, rising market interest rates cause existing bond prices to fall.

b. ✗ Incorrect. Policy timeline error: the 2024 budget proposed increasing the capital gains inclusion rate to two-thirds on higher gains, but this proposal was formally withdrawn in March 2025, leaving the current rate at 50% (consistent with the exam benchmark); additionally, interest income receives no tax credit.

c. ✗ Incorrect. Double error: systematic market risk affects the entire market and cannot be eliminated through diversification; furthermore, foreign dividends do not qualify for the Canadian eligible dividend tax credit.

d. ✗ Incorrect. Only net capital losses realized in non-registered accounts can be carried back 3 years or carried forward indefinitely to offset taxable capital gains; losses inside registered accounts cannot be used to offset taxable gains under non-registered rules.

147 answer d

a. ✗ Incorrect. Omits the 10-year inflation compounding factor (calculating only $80,000 * 60% = $48,000), ignoring the effect of prices compounding at 3% annually over 10 years.

b. ✗ Incorrect. Uses the wrong percentage: multiplies by the 40% spending reduction ($80,000 * 1.344 * 40% = $43,008) rather than the 60% post-retirement spending level retained.

c. ✗ Incorrect. Calculation error: after compounding for inflation to arrive at $107,520, mistakenly subtracts a fixed dollar amount of $40,000, treating a 40% drop as a $40,000 deduction.

d. ✓ Correct. Compounding current living expenses for inflation over 10 years and multiplying by the 60% spending retention ratio: $80,000 * 1.344 * 60% = $107,520 * 60% = $64,512 (approximately $64,508 if unrounded factors are used).

147′ answer a

a. ✓ Correct. The exam manual was drafted in 2022 and covers only the first tier of CPP (YMPE and the $3,500 basic exemption); the second tier (CPP2 / YAMPE), phased in during 2024—2025, applies a 4% contribution on the $10,400 earnings band between $74,600 and $85,000 (up to $416 each for employer and employee), which if omitted would underestimate government retirement income for higher-earning clients.

b. ✗ Incorrect. Factually reversed: the 2022 exam reference manual makes no mention of YAMPE (CPP2), and the $3,500 basic exemption for tier-one CPP remains unchanged.

c. ✗ Incorrect. Confuses CPP rules with RRSP limits: 18% and $33,810 represent the 2026 formula for generating new RRSP contribution room, not CPP contribution rules.

d. ✗ Incorrect. The $65,000 figure was an illustrative annual salary in Case 2, not a statutory CPP earnings limit (the 2026 YMPE is $74,600 and the YAMPE ceiling is $85,000).

Chapter 22 answers and reasons

148 answer a

a. ✓ Correct. Under BC Insurance Act s. 65(1), as long as a valid non–estate beneficiary is designated (whether friend Daniel or spouse Elena), the death benefit is paid directly to the beneficiary, bypassing probate; however, under s. 65(2), lifetime protection from creditor execution or seizure applies only when designating the annuitant's spouse, child, grandchild, or parent, without requiring the designation to be irrevocable.

b. ✗ Incorrect. Under BC Insurance Act s. 65(2), designating the annuitant's spouse, child, grandchild, or parent confers lifetime protection against seizure, and the law does not require the designation to be irrevocable; this falls into the trap of conflating probate bypass with creditor protection requirements.

c. ✗ Incorrect. While naming friend Daniel as a non–estate beneficiary bypasses probate, he does not fall within the family member class specified in BC Insurance Act s. 65(2) (spouse, child, grandchild, or parent), so the contract receives no statutory creditor protection; this is a trap that conflates the two protection conditions.

d. ✗ Incorrect. Designating a qualifying non–estate beneficiary ensures proceeds are paid directly to the beneficiary without entering the estate, thereby bypassing approximately $3,650 in tiered probate fees under the Probate Fee Act (as well as avoiding the general court application fee when there are no other probated assets, stated as $208 on the exam benchmark versus $200 under current BC Supreme Court Civil Rules).

148′ answer b

a. ✗ Incorrect. Daughter Chloe falls within the family beneficiary class under BC Insurance Act s. 65(2) (spouse, child, grandchild, parent), so even a revocable designation enjoys lifetime creditor protection without needing to be irrevocable; this falls into the trap of conflating probate bypass with creditor protection requirements.

b. ✓ Correct. Designating adult daughter Chloe (the annuitant's child) satisfies both the non–estate beneficiary condition to bypass probate and the family member class condition under BC Insurance Act s. 65(2) for creditor protection; tiered probate fees on a $300,000 estate equal $25,000 * 0 + $25,000 * 0.006 + $250,000 * 0.014 = $3,650, plus the general court application fee (note: stated as $208 on the exam benchmark, whereas current BC Supreme Court Civil Rules Schedule 1 sets it at $200, bringing total current court costs to approximately $3,850).

c. ✗ Incorrect. The BC Probate Fee Act exempts the first $25,000, charges $6 per $1,000 on $25,000 to $50,000, and levies $14 per $1,000 only on the portion exceeding $50,000; furthermore, protection for children under BC Insurance Act s. 65(2) does not depend on whether the child is an adult.

d. ✗ Incorrect. As long as a valid non–estate beneficiary is designated in a non–registered segregated fund contract, death benefit proceeds bypass the estate, avoiding probate and the $3,650 in tiered probate fees without needing to be held in a registered account.

149 answer b

a. ✗ Incorrect. The 75% maturity guarantee ($50,000 * 75% = $37,500) triggers only on the exact 10–year contract maturity date or upon the annuitant's death, and early surrender receives no top–up; this is the classic trap of erroneously applying guarantee top–ups to early redemptions.

b. ✓ Correct. Maturity guarantees and death benefit guarantees in segregated funds take effect only upon two specific events: contract maturity or the annuitant's death; because Owen surrenders fully in Year 7, he receives only the current market value of $32,000, and the insurer provides no top–up.

c. ✗ Incorrect. Once the entire contract is surrendered in Year 7, the insurance contract terminates immediately, the original Year 10 maturity guarantee ($37,500) is extinguished, and no future top–up will be paid.

d. ✗ Incorrect. Segregated funds have no five–year principal guarantee rule; maturity guarantees typically require a minimum 10–year term, and early redemptions during the contract term expose the investor to full market downside risk.

149′ answer c

a. ✗ Incorrect. Settlement of the maturity guarantee is a contractual obligation of the insurer that occurs automatically on the maturity date, requiring no claim application from the investor.

b. ✗ Incorrect. The contract's agreed maturity guarantee ratio is 75% ($37,500) rather than 100%, so the insurer is only obligated to top up the value to $37,500.

c. ✓ Correct. On the 10-year maturity date, because the market value of $30,000 is below the guaranteed amount of $37,500 ($50,000 * 75%), the insurer automatically fulfills its contractual obligation by funding a $7,500 top-up from its own assets to bring the contract value to $37,500, without requiring the investor to file a claim.

d. ✗ Incorrect. Top-ups triggered by routine market declines are paid from the insurer's own reserve assets; Assuris intervenes only if the life insurance company becomes insolvent and cannot meet its obligations.

150 answer c

a. ✗ Incorrect. The 10-year minimum term applies only to maturity guarantees, whereas the death benefit guarantee is effective from day one of the contract and triggers immediately upon the annuitant's death at any point; this falls into the trap of confusing maturity guarantee with death benefit guarantee.

b. ✗ Incorrect. In a 75%/100% structure, the first number 75% ($30,000) is the maturity guarantee, while the second number 100% ($40,000) is the death benefit guarantee; furthermore, even if the guarantee were lower than market value, the beneficiary would receive the higher market value rather than the lower guarantee.

c. ✓ Correct. The second number in a 75%/100% guarantee structure represents a 100% death benefit guarantee ($40,000), which takes effect from day one of the contract without waiting 10 years; when the annuitant dies in Year 6 with a market value of $36,500 below $40,000, beneficiary Hannah receives $40,000 (including a $3,500 top-up from the insurer).

d. ✗ Incorrect. Hannah is a validly designated non-estate beneficiary, so the death benefit is paid directly to her, completely bypassing the probate process.

150′ answer a

a. ✓ Correct. Upon the annuitant's death, the beneficiary receives the greater of the current market value ($52,000) and the death benefit guarantee ($40,000 * 100% = $40,000); because the $52,000 market value exceeds the guarantee, no top-up is triggered, and Hannah receives the full $52,000.

b. ✗ Incorrect. The death benefit guarantee serves as a floor rather than a cap; when market value exceeds the guaranteed amount, the beneficiary receives the full appreciated market value of $52,000.

c. ✗ Incorrect. 75% ($30,000) is the maturity guarantee percentage rather than the death benefit guarantee percentage, and whenever market value ($52,000) exceeds the guaranteed amount, the higher market value is paid; this falls into the trap of confusing maturity guarantee with death benefit guarantee.

d. ✗ Incorrect. The segregated fund guarantee is a top-up mechanism, not a separate fixed $40,000 life insurance death benefit stacked on top of market value.

151 answer d

a. ✗ Incorrect. A reset adjusts the guarantee base upward to the current market value of $90,000 (new guarantee $67,500) upon exercise, but the trade-off is extending the maturity date 10 years from the reset date rather than keeping the original maturity date at age 50.

b. ✗ Incorrect. A reset adjusts the base to the current market value of $90,000, but because the contract's guarantee tier is 75%, the new maturity guarantee is $90,000 * 75% = $67,500, not 100% ($90,000).

c. ✗ Incorrect. A maturity guarantee reset recalculates the 10-year guarantee period from the reset date (age 45), extending the new maturity date to age 55; one cannot lock in a higher guarantee while retaining the original maturity date at age 50.

d. ✓ Correct. After exercising the reset, the new guarantee is calculated as 75% of the $90,000 market value on the reset date, increasing from $45,000 to $67,500; simultaneously, the maturity date extends 10 years from the reset date (age 45) to Year 15, maturing when Sophia reaches age 55.

151′ answer a

a. ✓ Correct. Although a reset increases the guarantee from $45,000 to $67,500, it extends the maturity date from age 50 to age 55; if Sophia withdraws her funds at age 50 as originally planned, it will be treated as an early surrender before maturity, settling strictly at market value without maturity guarantee protection and mismatching her time horizon.

b. ✗ Incorrect. Following a reset, the new maturity date extends to age 55, so withdrawing funds at age 50 is an early redemption before maturity that cannot trigger the $67,500 maturity guarantee; this falls into the trap of erroneously applying guarantee top-ups to early redemptions.

c. ✗ Incorrect. Whether to execute a reset must be evaluated against the client's financial timeline, costs, and withdrawal restrictions, rather than relying on an agent's forecast of market gains.

d. ✗ Incorrect. Contracts with a reset feature permit exercising resets during the contract term (e.g., once annually up to a specified age limit), without requiring the client to wait the full 10 years.

152 answer a

a. ✓ Correct. Under the 2022 LLQP exam benchmark, Assuris protects segregated fund guarantees or cash values up to $60,000 or 85% of the guaranteed amount, whichever is higher (capped at the original guarantee); note that effective May 29, 2023, the current Assuris standard was increased to $100,000 or 90%, whichever is higher.

b. ✗ Incorrect. Up to $100,000 or 90% is the current Assuris standard following the May 29, 2023 increase, whereas the 2022 exam benchmark uses $60,000 or 85% for segregated fund guarantees; this falls into the trap of misaligning dual-benchmark figures with regulatory bodies.

c. ✗ Incorrect. Up to $200,000 or 85% was the 2022 exam benchmark for individual life insurance death benefits (currently updated to $1,000,000 or 90%), not the standard for segregated fund guarantees.

d. ✗ Incorrect. A monthly income cap of $2,000 or 85% was the 2022 exam benchmark for annuity monthly income (currently updated to $5,000 per month or 90%), which does not apply to lump-sum segregated fund principal guarantees.

152′ answer d

a. ✗ Incorrect. $37,500 is the result of applying a 75% guarantee to a $50,000 deposit; once the original contract guarantee is already $50,000, Assuris retains 100% of that guarantee because it is below the $60,000 threshold.

b. ✗ Incorrect. Assuris protection boundaries never elevate the original benefit; an original guarantee of $50,000 will never become $60,000 simply because of the $60,000 threshold; this is a trap confusing protection thresholds with actual benefits.

c. ✗ Incorrect. Assuris provides protection only within the scope of the original promised benefit and does not elevate a $50,000 contract guarantee to $100,000.

d. ✓ Correct. Under the 2022 exam benchmark, Assuris protects segregated fund guarantees up to $60,000 or 85%, whichever is higher (capped at the original benefit); because the original guarantee of $50,000 does not exceed the $60,000 threshold, it is retained 100% in full at $50,000 (note: current Assuris standards effective May 29, 2023 raised this to $100,000 or 90%, which also retains $50,000 in this scenario).

153 answer b

a. ✗ Incorrect. Under the common deposit date–based contract structure, each subsequent deposit calculates its own 10–year guarantee period independently rather than maturing alongside the initial deposit at the end of Year 10; this is the trap of consolidating maturity dates for subsequent deposits.

b. ✓ Correct. Under a deposit date–based structure, the first deposit matures at the end of Year 10 (guarantee $10,000 * 75% = $7,500), and the second deposit made at the start of Year 2 completes its 10 years at the end of Year 11 (adding $7,500, bringing cumulative matured guarantees to 2 * $10,000 * 75% = $15,000), while the third deposit matures at the end of Year 12 (reaching $22,500).

c. ✗ Incorrect. Making subsequent deposits does not increase the 75% maturity guarantee ratio to 100%, and the third deposit will not reach 10 years until the end of Year 12; thus, the cumulative matured guarantee at the end of Year 11 is $15,000 rather than $30,000.

d. ✗ Incorrect. Subsequent deposits run their own independent 10–year maturity clocks from each deposit date and do not push back the maturity date of the first deposit like an exercised reset does.

153′ answer c

a. ✗ Incorrect. A partial withdrawal causes a permanent reduction in the original guarantee base; any funds redeposited later are treated as new deposits with new maturity clocks, incapable of restoring the reduced guarantee base.

b. ✗ Incorrect. A partial withdrawal alters the principal base on which the guarantee is calculated, whereas the contractual guarantee percentage (such as 75%) remains unchanged.

c. ✓ Correct. A partial withdrawal during the contract term is treated as a partial surrender, permanently reducing the principal base on a proportional basis; while the 75% guarantee ratio remains unchanged, the smaller base permanently lowers future dollar amounts for both maturity and death benefit guarantees.

d. ✗ Incorrect. Whether instructions are verbal or written, the transaction is legally binding and withdrawals always permanently reduce the guarantee base proportionally.

154 answer d

a. ✗ Incorrect. The death benefit guarantee pays out to the beneficiary only upon the annuitant's death and cannot provide a continuous lifetime income stream to a living investor; this falls into the trap of confusing maturity guarantee with death benefit guarantee.

b. ✗ Incorrect. A front–end load (FEL) is merely a sales charge deducted upon initial purchase; it neither eliminates the ongoing management expense ratio (MER) nor provides any guaranteed lifetime income.

c. ✗ Incorrect. A Guaranteed Minimum Withdrawal Benefit (GMWB) guarantees a minimum annual withdrawal amount over a specified term, whereas a GLWB extends that withdrawal guarantee for life.

d. ✓ Correct. A Guaranteed Lifetime Withdrawal Benefit (GLWB) rider is an income–oriented guarantee (typically requiring an additional rider fee) that continues paying scheduled withdrawals for life even if market volatility and withdrawals reduce market value to zero, transferring longevity risk to the insurer; moreover, completing the investor profile prior to recommending products complies with Fair Treatment of Customers (FTC) principles and suitability sequencing.

154′ answer a

a. ✓ Correct. Under the Fair Treatment of Customers (FTC) principle and suitability requirements, the agent must complete the investor profile first (verifying investment objectives, risk tolerance, and time horizon) before matching products; under Canadian Investment Funds Standards Committee (CIFSC) standards, underlying investments are grouped into five asset classes: cash, fixed income, equity, commodities, and other (with the exam benchmark classifying them into approximately 14 sub–categories for instructional purposes).

b. ✗ Incorrect. Recommending products based on commission levels or selecting a product first and backfilling the investor profile violates FTC principles and suitability obligations.

c. ✗ Incorrect. Segregated fund market values fluctuate daily during the contract term, and early redemptions bear full market downside risk, meaning principal risk remains; therefore, the investor profile and suitability assessment can never be omitted.

d. ✗ Incorrect. CIRO regulates mutual funds and investment dealers and has no jurisdiction over segregated fund sales; this falls into the trap of misaligning dual–benchmark figures with regulatory bodies.

Chapter 23 answers and reasons

155 answer b

a. ✗ Incorrect. Falls into the Equating Deferred Annuities with Periodic Deposits trap: The sole criterion distinguishing an immediate annuity from a deferred annuity is when income payments begin, regardless of whether deposits are made as a lump sum or in installments.

b. ✓ Correct. A deferred annuity consists of two distinct stages: an accumulation phase and a payout phase. Funds deposited during the accumulation phase can be either a lump sum or periodic contributions; as long as payments commence only after the accumulation phase ends (in this case, 5 years later), the contract is classified as a deferred annuity.

c. ✗ Incorrect. An immediate annuity must begin payments within the first payment interval (within one year) following contract issue; beginning payments 5 years later represents an accumulation deferral period, not a 5–year guaranteed period.

d. ✗ Incorrect. A deferred annuity can certainly be purchased with a single lump sum, and a non–registered annuity with a 5–year accumulation phase reports taxes on an accrual basis during accumulation, being reassessed for prescribed annuity status only in the year payments begin.

155′ answer a

a. ✓ Correct. An immediate annuity must be purchased with a single lump sum and begin payments within the first payment interval (within one year); periodic contributions occur solely during the accumulation phase of a deferred annuity, and an immediate annuity funded through installment deposits does not exist.

b. ✗ Incorrect. Once an annuity enters the payout phase, the contract no longer accepts additional deposits; adding funds generally requires purchasing a separate, new annuity contract.

c. ✗ Incorrect. Periodic contributions occur only during the accumulation phase of a deferred annuity; a client cannot make installment deposits while simultaneously receiving immediate income from the same payout annuity.

d. ✗ Incorrect. A guaranteed period is a death benefit provision ensuring that remaining scheduled payments are made to a beneficiary if the annuitant dies prematurely; it has no bearing on whether premium deposits can be made in installments.

156 answer c

a. ✗ Incorrect. $2,000 per month is not an absolute ceiling; rather, it is compared against 85% of promised payments to determine coverage under the higher of the two ($2,000 per month or 85%, whichever is higher).

b. ✗ Incorrect. 90% is the current proportion following the 2023 update, but even under the 2026 current benchmark (the higher of $5,000 per month or 90%), a $5,000 monthly payment receives full 100% protection ($5,000) rather than $4,500.

c. ✓ Correct. The question explicitly specifies applying the 2022 exam benchmark: monthly payout annuity protection is the higher of $2,000 per month or 85% of promised payments; since $5,000 x 85% = $4,250, which exceeds $2,000, the covered amount is $4,250. (Under current rules since May 29, 2023, the limit is the higher of $5,000 per month or 90%, which would provide full protection for this $5,000 monthly benefit).

d. ✗ Incorrect. $100,000 is the protection threshold for accumulation annuity contract values, not an annual payout annuity limit; full protection for $5,000 per month reflects the post–May 2023 current standard rather than the 2022 exam curriculum benchmark.

156′ answer d

a. ✗ Incorrect. $4,250 (85%) is the obsolete 2022 exam curriculum figure; the question explicitly instructs applying current standards.

b. ✗ Incorrect. The current rule provides the higher of $5,000 per month or 90% of promised payments; since max($5,000, $4,500) = $5,000, the client receives $5,000 rather than $4,500.

c. ✗ Incorrect. Effective May 29, 2023, the base monthly dollar threshold for payout annuities was raised from $2,000 per month to $5,000 per month.

d. ✓ Correct. Under current 2026 Assuris standards, monthly payout annuity coverage is the higher of $5,000 per month or 90% of promised payments; therefore, a promised monthly payment of $5,000 receives max($5,000, $4,500) = $5,000 in full protection (note: under the 2022 exam benchmark, it was the higher of $2,000 per month or 85%, which equaled $4,250).

157 answer a

a. ✓ Correct. The monthly taxable portion is $200, resulting in an annual taxable amount of $200 x 12 = $2,400 (the $500 monthly capital return is non–taxable); a qualifying non–registered prescribed annuity under ITR section 304 generally maintains a level taxable portion across equal installments throughout the payout period.

b. ✗ Incorrect. While registered annuity payments are generally taxable in full, non–registered annuity payments comprise both return of capital ($500 per month) and interest ($200 per month); only the interest component ($2,400 annually) constitutes taxable income.

c. ✗ Incorrect. $6,000 ($500 monthly taxable) represents an illustrative figure from an accrual (non–prescribed) example where early years carry higher taxable amounts; in practice, varying life spans, annual marginal tax rates, and income–tested benefit clawbacks mean simplified curriculum comparisons cannot be taken as a tax guarantee that lifetime taxes paid are identical.

d. ✗ Incorrect. Canadian tax rules do not allow non–registered annuities to return 100% of capital tax–free before taxation begins; rather, each installment splits capital return and taxable interest in accordance with ITR section 300.

157′ answer c

a. ✗ Incorrect. Prescribed level capital–and–interest taxation applies only once equal annuity payments have commenced; during the accumulation phase, there are no periodic installments to split.

b. ✗ Incorrect. Deferring payout commencement does not permanently forfeit prescribed annuity eligibility; upon entering the payout phase, prescribed status is reassessed under ITR section 304 in that taxation year.

c. ✓ Correct. During the 5–year accumulation phase, a non–registered deferred annuity generally reports accrued income annually on an accrual basis (even without receiving cash); upon entering the payout phase, eligibility is reassessed in that year under ITR section 304, and if all conditions are met, the contract switches to prescribed taxation.

d. ✗ Incorrect. During the non–registered accumulation phase, accrued income must be reported annually for tax purposes even though no cash distributions have been received.

158 answer d

a. ✗ Incorrect. Falls into the Paying Beneficiaries Immediately Upon the First Annuitant's Death trap: Under a joint and last survivor annuity, when the first annuitant dies, the second annuitant is still living; the beneficiary Colin has no right to claim the remaining guaranteed period balance at this point.

b. ✗ Incorrect. The guaranteed period is shared jointly across both lives and runs continuously from the initial payout commencement date; it is never reset to run for a new 10–year term upon the first annuitant's death.

c. ✗ Incorrect. A joint and last survivor annuity may specify a survivor benefit percentage (such as 100%, 75%, 60%, or 50%), but this does not allocate any difference to a beneficiary; beneficiary rights can only be triggered after both annuitants have died.

d. ✓ Correct. A joint and last survivor annuity covers two lives; upon the first annuitant's death, the second annuitant continues receiving payments as the sole annuitant. The guaranteed period runs continuously from contract inception, and only if the second annuitant Beatrice also dies before the original 10–year guaranteed period expires does the beneficiary Colin become entitled to the remaining guaranteed balance.

158′ answer b

a. ✗ Incorrect. The guaranteed period is shared between both annuitants and runs from the contract's initial payment date; it does not reset when the first spouse passes away in year 5.

b. ✓ Correct. The 10–year guaranteed period began at contract inception and was fully satisfied at the end of year 10; because the second annuitant died in year 12, beyond the guaranteed period, no guaranteed balance remains for the beneficiary (unless the policy includes separate refund provisions).

c. ✗ Incorrect. Payout installments from year 5 through year 10 were already collected by the surviving spouse personally and were not accumulated for the beneficiary.

d. ✗ Incorrect. A guaranteed period secures the difference between total payments scheduled for the guarantee period and amounts already received; it is not an independent supplementary 10–year benefit payable over and above what was already distributed.

159 answer a

a. ✓ Correct. An Advanced Life Deferred Annuity (ALDA) is subject to a 25% transfer limit from each qualifying source plan, has a proposed lifetime cumulative cap of $150,000 under the exam benchmark (note: CRA indexed limits were $160,000 in 2022 and $180,000 in 2026), and payments must commence no later than the end of the calendar year in which the annuitant reaches age 85.

b. ✗ Incorrect. 50% is the maximum for eligible pension income splitting, $100,000 is the Assuris accumulation annuity protection limit, and age 71 is the deadline in the exam curriculum for VPLA commencement (as well as converting RRSPs to RRIFs or annuities).

c. ✗ Incorrect. Extending to age 90 is the duration requirement when purchasing a term-certain annuity with RRSP or RRIF funds, whereas an ALDA is a deferred life annuity whose lifetime payments must begin no later than the end of the year the annuitant turns age 85.

d. ✗ Incorrect. An ALDA cannot receive 100% of a single source plan's balance, as it must satisfy the 25% transfer test per qualifying plan; furthermore, requiring at least 10 members is an establishment condition for a Variable Payment Life Annuity (VPLA).

159′ answer b

a. ✗ Incorrect. The end of the year turning age 85 is the unique deferral limit for an ALDA; this age ceiling cannot be applied to a VPLA.

b. ✓ Correct. The exam curriculum specifies that a Variable Payment Life Annuity (VPLA) must commence payments by age 71 (note: under current ITR section 8502(e)(i)(C), the deadline is the later of the end of the year turning 71 or the end of the year in which the right is acquired), whereas an ALDA permits deferring payout commencement up to the end of the calendar year in which the annuitant reaches age 85.

c. ✗ Incorrect. A VPLA has no requirement to commence within one year after age 60, and the latest commencement deadline for an ALDA is the end of the year turning age 85 rather than age 90.

d. ✗ Incorrect. Requiring at least 10 members with an ongoing reasonable expectation to maintain that count is a formation condition for a VPLA mortality pool under ITR section 8506; it does not waive the commencement deadline of age 71 (or the end of the year rights are acquired).

160 answer b

a. ✗ Incorrect. Falls into the Assuming Adding a Guaranteed Period Benefits the Annuitant trap: Payout rates for fixed annuities are locked in on the date of contract issue and do not require a guaranteed period to protect against falling interest rates; adding a 20-year guaranteed period forces the insurer to price in the mortality shortfall risk, reducing the couple's monthly income while both are living.

b. ✓ Correct. A guaranteed period protects designated beneficiaries after both annuitants pass away rather than enhancing income for the annuitants themselves; when clients explicitly desire no estate legacy and want to maximize monthly income during their lifetime, omitting the guaranteed period avoids any discounting of periodic payments.

c. ✗ Incorrect. A joint and last survivor annuity can be structured with or without a guaranteed period; there is no statutory requirement mandating a 10-year guaranteed period.

d. ✗ Incorrect. A term-certain annuity does not transfer longevity risk; if the couple outlives the fixed term, payments cease entirely, defeating the goal of guaranteed lifetime income.

160′ answer c

a. ✗ Incorrect. Both single life annuities irrevocably commit the deposited capital; adding a 20-year guaranteed period requires the insurer to assume additional premature death liabilities, which inevitably discounts the periodic payout amount.

b. ✗ Incorrect. Adding death benefit protection (such as a guaranteed period) to the same contract increases the insurer's actuarial liabilities, resulting in an initial monthly payout that is strictly lower than a pure life annuity without a guarantee.

c. ✓ Correct. A guaranteed period essentially adds death benefit insurance to the longevity pooling arrangement; because the insurer assumes the extra liability of paying the beneficiary for the remainder of 20 years if the annuitant dies early, it discounts periodic payments. The longer the guaranteed period, the lower the monthly payout, meaning Quote 1 without a guarantee provides higher monthly income.

d. ✗ Incorrect. The monthly payment for a fixed annuity is locked into the contract from the date of issue and does not automatically adjust upward after the 20-year guaranteed period expires.

161 answer c

a. ✗ Incorrect. Falls into the Purchasing the Annuity Before Underwriting the Life Insurance in an Insured Annuity trap: If the annuity is purchased before applying for life insurance and the client is subsequently declined during medical underwriting, the in-force immediate annuity cannot be rescinded, causing the entire estate strategy to fail completely.

b. ✗ Incorrect. Permanent life insurance in an insured annuity (such as Term-100) must undergo standard medical underwriting; purchasing an annuity does not exempt the applicant from medical underwriting requirements.

c. ✓ Correct. The purchase sequence of an insured annuity cannot be reversed: medical underwriting for the permanent life insurance policy (such as Term-100) must be completed and the policy issued first; only then is separate capital used to purchase the single life annuity, using annuity payments ($1,300) to fund life insurance premiums ($1,000) and provide living income ($300).

d. ✗ Incorrect. An annuity with a 20-year guaranteed period is not an insured annuity; adding a guarantee reduces monthly income, and if Walter passes away after 20 years, his daughters would receive no remaining balance.

161′ answer b

a. ✗ Incorrect. The insured annuity strategy utilizes a single life annuity with no guaranteed period; upon the annuitant's death, the annuity terminates immediately and makes no further payments to beneficiaries.

b. ✓ Correct. In an insured annuity structure, annuity payments fund the permanent life insurance premiums while providing surplus income during the client's lifetime; upon the client's death, the single life annuity terminates, premium obligations cease, and the permanent life insurance death benefit is paid tax-free directly to the beneficiaries.

c. ✗ Incorrect. Permanent life insurance and the single life annuity are two distinct, independent contracts; the life insurance death benefit is never reduced by lifetime annuity payments already received (deducting cumulative payments is a feature of a capital protection guarantee).

d. ✗ Incorrect. Life insurance death benefits in Canada are paid tax-free to designated beneficiaries and are not taxed as prescribed annuity interest.

Chapter 24 answers and reasons

162 answer b

a. ✗ Incorrect. What a client wants is not necessarily what is suitable for the client, and clients frequently overestimate their own risk tolerance; subjective willingness cannot override the agent's professional judgment under the suitability principle (deferring to client subjective preference trap).

b. ✓ Correct. Risk tolerance (subjective psychological willingness) and risk capacity (objective financial ability) must be evaluated separately, with the lower of the two serving as the binding constraint for recommendations; because he is the sole household earner, holds emergency savings for only 3 months, and faces definite tuition payments in 3 years, his objective capacity is low, and short-term educational goals must be profiled separately from long-term wealth goals with full documentation.

c. ✗ Incorrect. Segregated fund maturity guarantees apply only on the contract maturity date or upon the annuitant's death; withdrawing funds after 3 years falls well short of the standard maturity date, meaning the client would fully bear any 20% interim market drop in principal.

d. ✗ Incorrect. The agent must faithfully record both the client's high risk tolerance and low risk capacity, and explain in the reason-why letter why advice is constrained by the lower capacity, rather than altering interview notes to fit the proposed product.

162′ answer d

a. ✗ Incorrect. Equating the added guarantee of segregated funds over mutual funds with being safer than GICs is a classic misconception; maturity guarantees apply only at maturity or death, so an investor needing interim withdrawals remains fully exposed to market losses in a 100% equity underlying portfolio.

b. ✗ Incorrect. The Fair Treatment of Customers (FTC) principles and suitability principle require products to match the client's actual situation; even if a client is persuaded and says they are willing to try, the agent cannot defer to subjective preferences exceeding financial capacity (deferring to client subjective preference trap).

c. ✗ Incorrect. With no income buffer beyond basic pensions, this $180,000 represents his only accessible savings, giving him very low objective risk capacity; compromising by placing half into a high-risk equity fund cannot substitute for the binding constraint.

d. ✓ Correct. Regardless of the client's subjective risk tolerance or risk perception, the agent must treat objective risk capacity as the binding upper limit, clarify that segregated fund guarantees apply only at maturity or death, and recommend a conservative allocation matching his low capacity and high liquidity needs.

163 answer a

a. ✓ Correct. The exam syllabus (§4.4.2) specifies only a single-tier contribution structure: an annual basic exemption of $3,500 (constant rule), above which earnings are subject to contributions up to the Year's Maximum Pensionable Earnings (YMPE). Note: The exam syllabus answer differs from current 2026 policy, which adds a second-tier ceiling, YAMPE ($85,000), above the first-tier YMPE ($74,600), assessing CPP2 at 4% on the intermediate $10,400 band (maximum annual contribution of $416 each for employee and employer).

b. ✗ Incorrect. CPP features an enduring $3,500 annual basic exemption and a ceiling on contributory earnings, rather than assessing contributions starting from the first dollar or continuing without a cap up to $90,000.

c. ✗ Incorrect. $74,600 is the 2026 first-tier YMPE ceiling rather than an exemption threshold, while 18% and $33,810 are parameters for calculating 2026 Registered Retirement Savings Plan (RRSP) new contribution room, completely unrelated to the CPP contribution formula.

d. ✗ Incorrect. CPP is a statutory mandatory government pension program for employment and self-employment earnings, completely unaffected by whether an individual holds a Tax-Free Savings Account (TFSA, 2026 annual limit $7,000), and provides no such exemption.

163′ answer c

a. ✗ Incorrect. The $3,500 annual basic exemption remains an enduring rule that has not been eliminated in 2026; the first-tier contributory earnings ceiling remains the $71,100 band between $3,500 and the YMPE ($74,600).

b. ✗ Incorrect. The 18% rate and $2,000 lifetime non-deductible overcontribution buffer are enduring rules for Registered Retirement Savings Plans (RRSPs), not CPP2 assessment rules; earnings exceeding the YAMPE ($85,000) are not subject to CPP2.

c. ✓ Correct. Under current 2026 rules, CPP operates under a two-tier structure: tier one runs from the $3,500 basic exemption to the YMPE ($74,600, maximum contributory earnings $71,100), and tier two assesses CPP2 at a 4% rate on the $10,400 band between the YMPE ($74,600) and the Year's Additional Maximum Pensionable Earnings (YAMPE, $85,000), resulting in a maximum annual contribution of $416 each for employee and employer. Note: The exam syllabus covers only tier one YMPE and omits tier two CPP2/YAMPE, but agents conducting retirement gap analyses for high-income earners must incorporate the second tier.

d. ✗ Incorrect. As long as employment earnings fall between the YMPE ($74,600) and the YAMPE ($85,000), CPP2 contributions are statutory and mandatory, and cannot be voluntarily opted out of or redirected into a First Home Savings Account (FHSA).

164 answer c

a. ✗ Incorrect. A Power of Attorney (POA) for property merely authorizes managing assets rather than transferring ownership, and signing for or managing investments does not confer authority to freely change beneficiaries (exaggerating Power of Attorney authority trap).

b. ✗ Incorrect. An attorney acting under a property POA has broad authority to manage assets when the grantor is incapacitated, including switching or selling investments; the restriction applies specifically to altering beneficiary designations, not routine investment switches.

c. ✓ Correct. An attorney acting under a Power of Attorney (POA) for property may switch or liquidate investments, but generally lacks authority to change beneficiary designations on life insurance or segregated fund (IVIC) contracts. Note: While the exam syllabus refers broadly to a BC exception, section 20 of the current BC Power of Attorney Act specifically provides that altering an existing beneficiary designation requires court authorization (renewing or replacing a similar instrument permits continuing the same beneficiary under statutory conditions, while creating a new instrument restricts any new designation to the grantor's estate).

d. ✗ Incorrect. Beneficiary alteration authority is governed by statutory POA legislation (such as BC Power of Attorney Act s.20), which is completely distinct from segregated fund Deferred Sales Charge (DSC) rules; the two must be verified separately and cannot be conflated.

164′ answer a

a. ✓ Correct. Under section 20 of the BC Power of Attorney Act: changing an existing beneficiary designation requires court authorization; renewing, replacing, or transferring into a similar instrument permits continuing the same beneficiary designated while the grantor had capacity, provided statutory conditions are met; and making a new designation under a fresh instrument is strictly restricted to the grantor's estate. Note: While the exam syllabus only mentions general restrictions and a BC exception in summary terms, practicing in BC requires understanding these precise statutory boundaries.

b. ✗ Incorrect. The BC exception noted in the exam syllabus does not grant an attorney free rein to substitute beneficiaries; altering an existing designation in BC requires court authorization, and a new designation under a fresh instrument is restricted to the grantor's estate (exaggerating Power of Attorney authority trap).

c. ✗ Incorrect. Without meeting statutory conditions under Power of Attorney Act s.20 or obtaining court authorization, an attorney cannot alter an existing beneficiary designation; verbal representations cannot substitute for court approval.

d. ✗ Incorrect. An attorney for property possesses legal authority to manage assets and execute applications to renew or replace contracts, and under s.20 conditions may retain the existing beneficiary or designate the grantor's estate under a new instrument.

165 answer d

a. ✗ Incorrect. This represents a classic error of substituting the client's chronological age for time horizon; time horizon depends on when the money will be spent, not on how old the client is today (substituting age for time horizon trap).

b. ✗ Incorrect. Neither TFSAs nor funds set aside for education carry a rule mandating liquidation within 3 years; Client Y's education goal matures in 20 years, representing a very long time horizon.

c. ✗ Incorrect. Time horizon in an investor profile is determined by the specific spending date of the investment objective, rather than a blanket assumption tied to statistical life expectancy.

d. ✓ Correct. Time horizon must be evaluated based on when the specific goal for the funds will occur, rather than using chronological age as a direct proxy: 28–year–old Client X needs the funds for a wedding in 2 years, making the time horizon short; 68–year–old Client Y is dedicating funds to a grandchild's education in 20 years with stable retirement income, making that goal's time horizon long.

165′ answer b

a. ✗ Incorrect. The same investor can have different time horizons and risk tolerances for different financial goals; investor profiles are built per goal rather than per person and must not be conflated.

b. ✓ Correct. Time horizon is determined by the specific goal attached to the funds: the TFSA savings earmarked for retirement have an actual horizon of 35 years, whereas the vacation funds needed next year have a very short horizon; separate investor profiles must be established for each distinct goal (reverse application of substituting age for time horizon trap).

c. ✗ Incorrect. Equating a young client with having a long time horizon for all funds requiring aggressive products is an error; vacation money needed next year requires high liquidity and has a short time horizon, so it must not be allocated to high–risk products simply because the client is young (substituting age for time horizon trap).

d. ✗ Incorrect. Money market segregated funds still require verifying fees, interim price fluctuations, and maturity guarantee dates, and cannot be treated identically to guaranteed bank deposits with zero principal loss; time horizon remains a fundamental KYC element.

166 answer b

a. ✗ Incorrect. A reverse mortgage is a liability, not an asset, and diminishes the estate left to heirs; additionally, while investment loans may be categorized as good debt, they are never exempt from repayment capacity and risk assessments.

b. ✓ Correct. When preparing a net worth statement, a reverse mortgage is an advance against home equity that must be repaid upon sale or death, eroding estate value, and must therefore be recorded as a liability rather than an asset; furthermore, whether assessing good debt used for appreciating assets or bad consumer debt, the ability to make scheduled payments remains critical in evaluating financial health.

c. ✗ Incorrect. Although a reverse mortgage generally requires no regular monthly payments while the owner lives in the home, the principal plus compounded interest must be repaid from sale proceeds or the estate, making it an essential liability that must appear on the net worth statement.

d. ✗ Incorrect. Consumer credit card balances represent bad debt that drains wealth, while a Pension Adjustment (PA) reflects employer pension accruals reducing subsequent-year RRSP room and has no connection to reverse mortgages.

166′ answer a

a. ✓ Correct. The Notice of Assessment (NOA) verifies an individual's RRSP deduction limit (reflecting factors like the Pension Adjustment); because CRA online accounts do not update TFSAs in real time, available room must be verified through actual contribution and withdrawal records across all institutions; additionally, even if mortgages and HELOCs are considered good debt, scheduled repayment ability must be verified rather than ignored.

b. ✗ Incorrect. $109,000 is the cumulative lifetime room for an individual who turned 18 by 2009 and remained a resident each year, not an assumed available balance for everyone; moreover, ignoring a mortgage simply because it is considered good debt is a classic review oversight.

c. ✗ Incorrect. RRSP deduction limits must be verified against CRA Notices of Assessment (NOA) rather than utility bills; drawn HELOC balances represent liabilities on the net worth statement, not liquid assets.

d. ✗ Incorrect. CRA online account records for TFSAs do not track current-year transactions in real time, requiring verification of actual deposits and withdrawals across all institutions; furthermore, reverse mortgages are liabilities, not tax-free income.

167 answer a

a. ✓ Correct. KYC and the suitability principle represent ongoing obligations rather than a one-time onboarding formality; when a client experiences major life changes such as divorce or retirement, their time horizon and risk capacity change, so the agent cannot treat silence as implied consent and must implement periodic reviews with documented records (treating the profile as a one-time onboarding formality trap).

b. ✗ Incorrect. An investor profile is never permanently valid once completed at contract signing; it must be updated periodically and reassessed whenever major changes occur (treating the profile as a one-time onboarding formality trap).

c. ✗ Incorrect. Both changes in product features and material life events in a client's life (retirement, divorce, inheritance, unemployment) trigger the ongoing regulatory obligation to reassess suitability.

d. ✗ Incorrect. Even if the original holding is a balanced segregated fund, when divorce significantly reduces net worth and early retirement shortens the horizon while altering cash flow, the moderate-risk allocation may exceed current risk capacity, necessitating a formal review.

167′ answer d

a. ✗ Incorrect. Merely printing a commission illustration fails to prove that client needs and risk profiles were reassessed, and cannot serve as compliant evidence of a suitability review.

b. ✗ Incorrect. Leaving the education goal intact does not mean retirement savings are unaffected; early retirement directly shortens the time horizon for retirement assets and alters income structure, requiring a dedicated review of the retirement allocation.

c. ✗ Incorrect. Failing to keep written records deprives the agent of crucial defensive evidence if challenged by complaints or provincial regulatory inquiries from the Insurance Council of BC or BCFSA; suitability reviews require comprehensive written documentation.

d. ✓ Correct. A material change review record (reason–why or review record) serving as defensive evidence for an agent must include: the triggering event and date (early retirement), items reviewed (re–evaluating income replacement, shortened time horizon, and whether the original 13–year allocation remains suitable), review conclusions (such as leaving education intact while recommending a lower equity weighting for retirement), and the date of client acknowledgment.

168 answer c

a. ✗ Incorrect. Fair Treatment of Customers (FTC) is an overarching regulatory doctrine covering seven obligations across the full lifecycle from product design to claims settlement, whereas the specific alignment of whether this product fits this client in a single recommendation is governed by the subsidiary suitability principle; furthermore, post–sale disclosure can never validate an unsuitable recommendation driven by high commissions.

b. ✗ Incorrect. KYC is the process of collecting client identity, financial, objective, and risk data, and does not itself produce a product recommendation; furthermore, higher trailer fees or commissions never indicate that a product is safer or more suitable.

c. ✓ Correct. When asked which principle specifically governs product matching for a single recommendation, the answer is the suitability principle rather than the broad FTC doctrine (suitability is just one obligation under FTC); moreover, the exam syllabus explicitly emphasizes that commissions or trailer fees must not influence product comparisons, and the reason–why letter should document that compensation structure did not bias the recommendation.

d. ✗ Incorrect. The Pension Adjustment (PA) is a tax metric reducing subsequent–year RRSP room and has no relevance to product suitability matching; furthermore, commission levels must never influence suitability assessments under any circumstances.

168′ answer b

a. ✗ Incorrect. The suitability principle and Fair Treatment of Customers (FTC) exist at different regulatory tiers, and both operate across the entire client relationship rather than only at account opening; moreover, the reason–why letter is a written disclosure that must be discussed with the client and archived.

b. ✓ Correct. Fair Treatment of Customers (FTC) is an overarching regulatory principle spanning seven obligations across the entire sales cycle from product design to claims handling; KYC compiles information into an investor profile, the suitability principle bridges that profile to a tailored product recommendation (functioning as one core requirement of FTC), and the reason–why letter serves as critical compliance evidence documenting the recommendation rationale for the client and agency files.

c. ✗ Incorrect. Information gathered through KYC does not independently produce recommendations; the agent must apply the suitability principle to continuously compare product features against the client profile, and risk perception or questionnaires cannot substitute for full suitability analysis.

d. ✗ Incorrect. This completely reverses the hierarchical relationship between the suitability principle and Fair Treatment of Customers (FTC): FTC is the overarching doctrine spanning product design to claims settlement, whereas suitability specifically governs whether product recommendations match the client's profile.

Chapter 25 answers and reasons

169 answer b

a. ✗ Incorrect. Group segregated funds carry no death benefit guarantee by default; one cannot assume that because a product has 'segregated fund' in its name it possesses the 75% or 100% guarantee structure of individual segregated funds (product naming and dual–standard confusion trap).

b. ✓ Correct. In accordance with the recommendation decision tree rules, group segregated funds provide no death benefit guarantee by default; if the client's primary objective is principal protection upon death, the group segregated fund cannot satisfy it, requiring an evaluation of an individual segregated fund or life insurance.

c. ✗ Incorrect. A First Home Savings Account (FHSA) is a tax container for which eligibility to open and withdraw is verified for short–term home purchase goals, not an insurance product providing a 10–year maturity or death benefit principal guarantee (product naming and dual–standard confusion trap).

d. ✗ Incorrect. A contingent annuitant can only be named on non–registered contracts; registered retirement plans cannot designate a contingent annuitant, and this role does not create a death benefit principal guarantee that a group segregated fund does not already possess (registered account role splitting trap).

169′ answer d

a. ✗ Incorrect. Non–registered accounts can fully hold individual segregated funds with a choice of 75/75, 75/100, or 100/100 guarantee tiers; the conflict stems from the time horizon rather than account restrictions (registered account role splitting trap).

b. ✗ Incorrect. Individual segregated funds provide maturity and death benefit guarantee structures whether held in registered or non–registered accounts, and do not require being inside an RRSP to be effective (product naming and dual–standard confusion trap).

c. ✗ Incorrect. Payout annuities are designed for clients who are retired or nearing retirement and require stable lifetime or term income, not for short–term funds where principal will be withdrawn within two years to buy a home (product naming and dual–standard confusion trap).

d. ✓ Correct. The time horizon must be determined by the actual intended use of the funds: individual segregated funds have a minimum 10–year maturity, which directly conflicts with the client needing the money to buy a home within two years; compliant practice is to first evaluate eligibility for tax containers such as an FHSA and then allocate to cash or short–term investments suited for short–term needs.

170 answer c

a. ✗ Incorrect. In individual retirement registered contracts, the contract owner and the annuitant must be the same person; furthermore, in a spousal RRSP, the contributing spouse holds no ownership rights whatsoever, making both proposals legally invalid (registered account role splitting trap).

b. ✗ Incorrect. While the first statement is correct, the second statement reverses the ownership rules of a spousal RRSP: contributing funds and holding ownership are separate matters, and the contributing spouse holds no ownership rights in a spousal RRSP and cannot designate the beneficiary (registered account role splitting trap).

c. ✓ Correct. Accurately identifies two core rules: first, in registered contracts such as individual RRSPs, the contract owner and the annuitant must be the same person; second, in a spousal RRSP, the spouse receiving the contribution (the wife) is both the owner and the annuitant, and only she may designate the beneficiary, while the contributing spouse retains no ownership rights.

d. ✗ Incorrect. A contingent annuitant is permitted only in non–registered contracts; registered contracts cannot designate a contingent annuitant, nor can they separate the contract owner from the annuitant (registered account role splitting trap).

170′ answer a

a. ✓ Correct. Non–registered contracts offer high flexibility: the contract owner can be different from the annuitant (the owner can be an individual, multiple persons, or a corporation), ownership can be transferred or pledged as loan collateral, and a contingent annuitant may be designated while the original annuitant is alive.
b. ✗ Incorrect. This restriction applies strictly to individual retirement registered contracts; applying registered contract restrictions to non–registered contracts represents a classic confusion (registered account role splitting trap).
c. ✗ Incorrect. Although registered accounts mandate providing a Social Insurance Number (SIN), non–registered contracts that generate reportable investment income also require a SIN for tax purposes (agent completion equated to agent decision trap).
d. ✗ Incorrect. Confuses the roles of the contract owner, annuitant, and beneficiary: death benefits are pegged to the life of the annuitant, and the beneficiary only gains entitlement after the death of the last surviving annuitant (registered account role splitting trap).

171 answer a

a. ✓ Correct. Under the exam standard, when an investor cannot sign personally due to illness, incapacity, or extended absence abroad, an attorney acting under a Power of Attorney (POA) for property may sign the application form, but this exception does not include the authority to designate or change beneficiaries. While the exam standard noted a BC exception, under British Columbia's current Power of Attorney Act s.20, an attorney altering an existing beneficiary designation from the husband to grandchildren still requires prior court authorization.
b. ✗ Incorrect. Overlooks the statutory exception for signing application forms: when an investor is ill, incapacitated, or abroad for an extended period, an attorney under a Power of Attorney (POA) for property may complete and sign the application form on their behalf (Power of Attorney exceeding authority to alter beneficiaries trap).
c. ✗ Incorrect. Mistakes the exception for signing an application form as granting the attorney the authority to do everything an owner can do; the authority to sign is entirely separate from designating or altering beneficiaries, and neither the national exam default rule nor BC's current s.20 permits changing beneficiaries at will (Power of Attorney exceeding authority to alter beneficiaries trap).
d. ✗ Incorrect. The advisor is only responsible for recording information provided by the client or authorized representative onto the form, and must never sign the application form or alter beneficiaries in place of the client or attorney (agent completion equated to agent decision trap).

171′ answer c

a. ✗ Incorrect. The exam standard explicitly states that when an investor cannot sign personally due to illness, incapacity, or living abroad for an extended period, an attorney under a Power of Attorney (POA) for property may sign the application form (Power of Attorney exceeding authority to alter beneficiaries trap).
b. ✗ Incorrect. The exception allowing signing the application form generally does not include the authority to designate or change beneficiaries, and signing authority cannot be broadly interpreted to permit altering beneficiaries at will (Power of Attorney exceeding authority to alter beneficiaries trap).
c. ✓ Correct. In accordance with the exam standard: living abroad for an extended period is an eligible exception allowing an attorney under a Power of Attorney (POA) for property to sign the application form, but this exception by default excludes the right to designate or change beneficiaries. Under BC's current Power of Attorney Act s.20, changing an existing beneficiary designation also requires court authorization.
d. ✗ Incorrect. Both beneficiary changes and recommendation compliance must strictly adhere to statutory authority boundaries and written documentation requirements; an advisor cannot exceed legal authority based merely on verbal communications with the attorney (verbal assent substituting for reason–why letter trap).

172 answer d

a. ✗ Incorrect. The exam standard explicitly stipulates that a reason–why letter is not optional and must highlight which needs remain unaddressed; concealing unaddressed needs undermines the client's right to informed decision–making (verbal assent substituting for reason–why letter trap).

b. ✗ Incorrect. Every recommendation requires preparing a reason–why letter during the application stage, and past performance in any event can never serve as the sole justification for a recommendation (verbal assent substituting for reason–why letter trap).

c. ✗ Incorrect. A recommendation that does not cover all of a client's needs does not equate to professional misconduct; the critical requirement is that unaddressed needs must be explicitly documented in the reason–why letter to ensure the client is informed.

d. ✓ Correct. A reason–why letter is not optional; it must be prepared during the application stage, reviewed thoroughly with the client, and retained in duplicate on file by both parties; its five core elements explicitly include confirming facts, verifying client instructions, identifying addressed and unaddressed needs, explaining the suitability rationale, and confirming client comprehension.

172′ answer b

a. ✗ Incorrect. A reason–why letter is designed to substantiate the suitability of the recommendation, not to promote three–year past performance rankings or solicit a waiver of the right of rescission from the client (verbal assent substituting for reason–why letter trap).

b. ✓ Correct. Fully aligns with the five elements of a reason–why letter mandated by the exam standard: confirming facts, verifying client instructions, identifying which needs are met and which remain unaddressed, explaining why the transaction is suitable (the suitability rationale), and confirming that the client understands what they are purchasing.

c. ✗ Incorrect. The reason–why letter, information folder, and Fund Facts serve separate and independent roles, and the letter cannot substitute for the three mandatory disclosure documents (product naming and dual–standard confusion trap).

d. ✗ Incorrect. The fourth element of the reason–why letter requires documenting the reasoning process behind the suitability determination rather than merely stating a final conclusion; otherwise, it lacks evidentiary weight during subsequent investigations (verbal assent substituting for reason–why letter trap).

173 answer b

a. ✗ Incorrect. Confuses the five–business–day deemed receipt triggering rule with the two–business–day time limit for the right of rescission itself, and the refund amount is the lesser rather than the greater value (product naming and dual–standard confusion trap).

b. ✓ Correct. Under the rules governing the right of rescission, an investor may rescind the contract 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 valuation date following the rescission request, along with any fees refunded.

c. ✗ Incorrect. Confuses the 10–year maturity guarantee with the two–business–day right of rescission following trade confirmation (product naming and dual–standard confusion trap).

d. ✗ Incorrect. December 31 of the previous year is the data cutoff date for the Fund Facts, not the deadline for exercising rescission; furthermore, delivering a sample contract does not complete a purchase, as the contract effective date is the valuation date following receipt of the initial deposit when all conditions are met (product naming and dual–standard confusion trap).

173′ answer a

a. ✓ Correct. The Fund Facts document is prepared individually for each specific fund chosen by the client, with data current as of December 31 of the previous year, follows an industry-wide standardized format to facilitate comparisons across funds, and must be reviewed with the investor by the advisor to answer any questions.
b. ✗ Incorrect. The information folder is prepared per contract product or series, and the advisor must ensure that the folder covers the client's actual contract and selected funds, rather than substituting a booklet from another series of the same insurer (product naming and dual-standard confusion trap).
c. ✗ Incorrect. Delivering a sample contract does not constitute completion of the purchase; the contract effective date is the valuation date following receipt of the initial deposit when all conditions are satisfied (product naming and dual-standard confusion trap).
d. ✗ Incorrect. The right of rescission is a contractual right set out in the information folder (derived from industry guideline standard practice rather than a statutory right in legislation), carries a time limit of two business days following receipt of confirmation (five business days is the benchmark for deemed receipt by mail), and refunds the lesser amount (product naming and dual-standard confusion trap).

174 answer a

a. ✓ Correct. First, the factual content of the segregated fund application form must be provided by the investor, with the advisor only recording and explaining information rather than deciding or fabricating details on the client's behalf; second, fund comparisons must follow the 'like' compared to 'like' discipline, and any cross-category comparison requires explaining the rationale to the client.
b. ✗ Incorrect. Mandatory conversion at age 71 and Advanced Life Deferred Annuity (ALDA) commencement limits at age 85 are statutory conversion rules for registered retirement accounts, unrelated to an advisor fabricating application information or conducting inappropriate cross-category comparisons (product naming and dual-standard confusion trap).
c. ✗ Incorrect. Maturity and death benefit guarantees are provided by the insurance company under an Individual Variable Insurance Contract (IVIC); the advisor does not personally guarantee principal, and non-compliance triggers compliance investigations and regulatory disciplinary proceedings (verbal assent substituting for reason-why letter trap).
d. ✗ Incorrect. Recording information provided by the investor onto an electronic or paper application form is a compliant operational duty; the misconduct lies in unilaterally deciding what content to enter rather than in physically handling the form (agent completion equated to agent decision trap).

174′ answer d

a. ✗ Incorrect. Total Cost Reporting (TCR) is an annual fee and guarantee cost disclosure rule effective January 1, 2026, not an overarching principles framework covering product design, promotion, conflict management, and complaint resolution across seven areas (product naming and dual-standard confusion trap).
b. ✗ Incorrect. Spousal RRSP rules establish that the contributing spouse has no ownership rights and cannot transfer the contract, which is unrelated to the seven overarching lifecycle regulatory requirements (registered account role splitting trap).
c. ✗ Incorrect. The five-business-day deemed receipt rule is strictly used to determine the start of the right of rescission period, not as an overarching framework of seven regulatory expectations across the full customer lifecycle (product naming and dual-standard confusion trap).
d. ✓ Correct. The seven expectations of the Fair Treatment of Customers (FTC) principles apply across the entire customer lifecycle: prioritizing client interests in product design and marketing, ensuring promotional materials are clear and not misleading, providing timely information throughout the contract life, managing conflicts of interest, minimizing unsuitable sales risks, ensuring relevant advice, and handling complaints fairly and promptly.

175 answer c

a. ✗ Incorrect. The advisor chargeback sales charge is a non-deferred commission structure retained in the market following the 2023 DSC ban; this term does not appear anywhere in the exam standard (product naming and dual-standard confusion trap).

b. ✗ Incorrect. When the 2022 exam standard was written, the ban was not yet in effect; furthermore, even after the ban on new contracts took effect on June 1, 2023, existing contracts continue their DSC redemption schedules based on their respective purchase dates and original schedules rather than having a unified reset date (product naming and dual-standard confusion trap).

c. ✓ Correct. 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. Note that the exam standard differs from current BC regulations: BC officially prohibited DSC on new segregated fund contracts under Financial Institutions Act s.244(2)(e)(ii) effective June 1, 2023, but exam questions about the sales charge types the exam materials list must still cover both FEL and DSC.

d. ✗ Incorrect. Section 20 of the Power of Attorney Act governs the requirement for an attorney under an enduring power of attorney to obtain court authorization before altering an existing beneficiary designation, which is entirely unrelated to segregated fund sales charges (Power of Attorney exceeding authority to alter beneficiaries trap).

175′ answer b

a. ✗ Incorrect. BC has prohibited deferred sales charges (DSC) on new segregated fund contracts under Financial Institutions Act s.244(2)(e)(ii) since June 1, 2023, and provincial regulators have adopted the Consolidated Segregated Funds Guidance as a regulatory expectation for BC licensees, making it improper to recommend DSC on new contracts (product naming and dual-standard confusion trap).

b. ✓ Correct. Effective June 1, 2023, British Columbia prohibited deferred sales charges (DSC) on new segregated fund contracts under Financial Institutions Act s.244(2)(e)(ii), meaning new contracts can only compare front-end load (FEL), no-load, or advisor chargeback arrangements; existing contracts continue their DSC redemption schedules normally based on each purchase date and the original schedule. The 2022 exam standard only stated DSC was expected to be phased out, while this question tests current 2026 practice.

c. ✗ Incorrect. Total Cost Reporting (TCR) rules taking effect January 1, 2026 introduce new annual fee disclosure standards; redemption schedules for existing DSC contracts run based on purchase dates and the original schedule, without any unified reset date (product naming and dual-standard confusion trap).

d. ✗ Incorrect. The statutory basis for BC's ban on new DSC contracts is Financial Institutions Act s.244(2)(e)(ii) governing market conduct, not the Insurance Act governing policy terms, and it does not mandate converting existing DSC units into a payout annuity at age 71 (product naming and dual-standard confusion trap).

Chapter 26 answers and reasons

176 answer b

a. ✗ Incorrect. Falls into the trap of naming a contingent annuitant on a registered contract. Although segregated funds are governed by provincial insurance legislation, registered plans (RRSP/RRIF/LIRA) legally mandate that the owner and annuitant be the same person and cannot be assigned or pledged; therefore, Contract X cannot designate a contingent annuitant or be pledged as collateral.

b. ✓ Correct. There is a structural distinction between registered and non-registered contracts: registered contracts (Contract X) legally bind the owner and annuitant as the same person, meaning the annuitant cannot be changed once designated, carries no contingent annuitant option, and cannot be assigned or pledged; only non-registered contracts (Contract Y) permit designating a contingent annuitant and pledging as collateral.

c. ✗ Incorrect. The first half falls into the trap of naming a contingent annuitant on a registered contract (an RRSP contract cannot have a contingent annuitant), while the second half overlooks that non-registered segregated fund contracts (Contract Y) are legally permitted to be assigned and pledged as loan collateral.

d. ✗ Incorrect. The prohibition against assigning or pledging registered contracts (such as RRSPs) is a statutory registered plan restriction that cannot be bypassed or waived by executing a contract amendment.

176′ answer d

a. ✗ Incorrect. Falls into the trap of naming a contingent annuitant on a registered contract. Only non-registered contracts permit role separation between the policy owner and annuitant and allow designating a contingent annuitant; a LIRA is a registered contract that legally mandates the owner and annuitant be the same person.

b. ✗ Incorrect. Non-registered segregated fund contracts permit the policy owner and annuitant to be separate persons, and allow naming a contingent annuitant during the primary annuitant's lifetime to succeed the contract upon their death.

c. ✗ Incorrect. A spousal waiver relates to locked-in pension death benefit entitlement or unlocking rules, and cannot override the structural registered contract rule requiring the owner and annuitant to be the same person or allow a contingent annuitant.

d. ✓ Correct. Registered plans (including LIRAs, RRSPs, and RRIFs) strictly require the owner and annuitant to be the same person, so the annuitant cannot be changed once designated and no contingent annuitant option exists; non-registered contracts, conversely, allow separating owner and annuitant and naming a contingent annuitant.

177 answer c

a. ✗ Incorrect. Contains two errors: first, the number of free switches per year is an administrative rule set at each insurer's discretion rather than a uniform statutory requirement; second, contract amendments or addenda waiving policy terms must be executed in writing by the insurer and signed by the policy owner to be valid, whereas verbal agreements by an advisor are legally void.

b. ✗ Incorrect. Reverses both rules: requiring the consent of an irrevocable beneficiary to make changes is a statutory requirement under the Insurance Act and a contractually fixed clause, whereas reset age limits and frequency caps are administrative rules set at each insurer's discretion.

c. ✓ Correct. Requiring the consent of an irrevocable beneficiary for changes is a statutory and contractually fixed clause; the annual number of free switches and specific short-term trading fees are determined by each insurer; and any amendment or addendum waiving contract terms must be prepared in writing by the insurer and signed by the policy owner to take effect, as verbal arrangements are legally void.

d. ✗ Incorrect. Maturity and death guarantee percentages are locked into the contract once selected and represent guaranteed obligations the insurer must fulfill, rather than administrative rules that can be unilaterally altered; only the specific POA forms and internal verification workflows are insurer-discretionary rules.

177′ answer a

a. ✓ Correct. The requirement that five core actions (purchase, switch, reset, withdrawal, and termination) must obtain investor confirmation is a contractually fixed or mandatory rule; the reset age ceiling is set at the insurer's discretion in the contract, and any amendment or addendum waiving or changing contract provisions must be prepared in writing by the insurer and signed by the policy owner to take effect, rendering verbal promises by an advisor void.

b. ✗ Incorrect. All five actions (purchase, switch, reset, withdrawal, and termination) strictly require investor confirmation, and any special term waivers verbally agreed upon between an advisor and client are legally non-existent unless executed as a written endorsement prepared by the insurer.

c. ✗ Incorrect. The reset age limit (such as age 80) is an administrative rule established by insurers to manage increased mortality risk at older ages, rather than a statutory provision fixed by the Financial Institutions Act.

d. ✗ Incorrect. Reset age ceilings and frequency limits are administrative rules established at each insurer's discretion, rather than uniform statutory mandates under the Insurance Act.

178 answer a

a. ✓ Correct. This question tests dual benchmarks between the exam curriculum and current BC rules: the 2022 exam benchmark states DSCs are expected to be phased out, whereas current rules prohibited issuing new DSC segregated fund contracts effective June 1, 2023; regarding statutory division, market conduct oversight such as the DSC ban is enforced under the Financial Institutions Act (FIA), while contract provisions such as beneficiary designations and creditor protection fall under Part 3 of the BC Insurance Act.

b. ✗ Incorrect. The 2022 exam benchmark already noted that regulators were moving to phase out DSCs, and British Columbia prohibited issuing new IVIC contracts with DSCs effective June 1, 2023 under s. 244(2)(e)(ii) of the Financial Institutions Act, rather than permanently permitting them.

c. ✗ Incorrect. Both the timeline and the statutory division are wrong: the ban on new insurance DSC contracts took effect on June 1, 2023 (the 2022 exam benchmark described it as expected to be phased out), and core contract clauses like beneficiary designations and creditor protection belong under Part 3 of the BC Insurance Act, not the FIA.

d. ✗ Incorrect. Legacy DSC contracts issued before June 1, 2023 are unaffected by the ban and run their normal redemption schedules to completion, and segregated funds are regulated under provincial insurance legislation (the Insurance Act and Financial Institutions Act) rather than federal banking legislation.

178′ answer c

a. ✗ Incorrect. Under both the exam benchmark and current rules, DSC is not a permanently preserved statutory option, and selling new segregated fund contracts with DSCs has been banned since June 1, 2023.

b. ✗ Incorrect. DSC was a historic sales charge option for segregated funds (IVICs) rather than payout annuities, and redemption schedules on legacy contracts sold before June 1, 2023 run their normal course rather than being voided.

c. ✓ Correct. Standard dual-benchmark response: if an exam question asks about status and trends under the 2022 benchmark tone, answer that regulators are moving to phase them out (expected to be phased out); if asked whether new DSC contracts can be sold today, answer no, because BC prohibited insurers from issuing new IVICs with DSCs effective June 1, 2023 under the Financial Institutions Act.

d. ✗ Incorrect. Following the phase-out of new DSC contracts, the market continues to offer front-end load, no-load, chargeback, or fee-based advisor options rather than collapsing into a single uniform pricing model, and the DSC ban is enforced under the FIA rather than the Insurance Act.

179 answer d

a. ✗ Incorrect. Falls into the zero–consequence free switch trap. Waiving transaction fees only means the insurer does not deduct an administrative transfer charge; a fund switch within a non–registered contract constitutes a disposition for tax purposes, and simultaneously triggering a maturity reset extends the maturity date.

b. ✗ Incorrect. Contains two errors: first, $86,000 – $80,000 = $6,000 is the total capital gain, resulting in a taxable capital gain of $3,000 under the 50% inclusion rate; second, triggering a maturity guarantee reset extends the 10–year maturity date by 10 years from the reset date.

c. ✗ Incorrect. Confuses tax rules between registered and non–registered contracts: switches within registered contracts do not trigger immediate capital gains reporting, but a switch in a non–registered contract is treated as a taxable disposition where proceeds exceeding the ACB must be reported as capital gains in that tax year without waiting for cash withdrawal.

d. ✓ Correct. A switch within a non–registered contract is treated as a taxable disposition regardless of whether transaction fees are waived: capital gain = $86,000 – $80,000 = $6,000, which produces a taxable capital gain of $3,000 at the 50% inclusion rate; concurrently, the maturity reset triggered by the switch steps up the guarantee base and restarts the 10–year maturity date from the reset date (extending it 4 years beyond the original schedule).

179′ answer b

a. ✗ Incorrect. Falls into the zero–consequence free switch trap. A fee–free switch merely waives the transfer charge; a switch in a non–registered contract still triggers a tax disposition, and a concurrent maturity reset restarts the 10–year maturity timeline.

b. ✓ Correct. The advisor's complete disclosure must cover three elements: (1) no administrative fee is charged for this switch; (2) the non–registered switch constitutes a tax disposition, generating a capital gain of $45,000 – $40,000 = $5,000, which yields a taxable capital gain of $2,500 at a 50% inclusion rate; and (3) the simultaneously triggered maturity reset extends the maturity date by 10 years from today (pushing it 6 years past the original 10–year term).

c. ✗ Incorrect. A short–term trading fee (such as 2%) is triggered only if units are switched within 90 days of purchase or deposit; because Miranda has held the units for 6 years and remains within the annual free switch allowance, no short–term trading fee applies.

d. ✗ Incorrect. Contract provisions state that triggering a maturity guarantee reset resets the maturity date (requiring another 10–year wait), and capital gains from non–registered switches must be reported in the tax year of the switch rather than deferred until contract maturity.

180 answer b

a. ✗ Incorrect. Falls into both the trap of mistaking lifetime incapacity for a death claim and the trap of ignoring proportional guarantee base reductions. A beneficiary has claim rights only upon the annuitant's death; because Walter is incapacitated but living, Fiona has no claim rights and no death–claim APS is required, and prior partial withdrawals have already reduced the guarantee base proportionally.

b. ✓ Correct. Evaluated in two stages: first, because the annuitant Walter is living when the contract matures, this is a maturity claim rather than a death claim, meaning beneficiary Fiona has no entitlement; Derek acts under a valid enduring Power of Attorney for property on behalf of the owner Walter, and maturity settlement requires no death certificate. Second, the partial withdrawal three years prior proportionally reduced the guarantee base, and because market value at maturity is below the adjusted guarantee, the payout equals the adjusted guarantee after accounting for the reduction.

c. ✗ Incorrect. A partial withdrawal proportionally reduces the guarantee amount rather than voiding the entire maturity guarantee, and beneficiary Fiona has no standing to participate in a maturity claim while the annuitant is living.

d. ✗ Incorrect. An estate representative (executor, administrator, or liquidator) claims only upon the annuitant's death when no surviving eligible beneficiary exists; while an incapacitated owner is living, the attorney under a POA manages maturity affairs on their behalf, and the guarantee amount reflects deductions for prior withdrawals.

180′ answer a

a. ✓ Correct. The annuitant Beatrice has died, triggering a death claim: the named beneficiary Chloe (not Lucas, the lifetime attorney under a POA) must submit the claim accompanied by proof of death and entitlement satisfactory to the insurer (such as a death certificate or APS), and the payout equals the higher of the market value and the death benefit guarantee as adjusted downward for prior withdrawals.

b. ✗ Incorrect. Confuses a maturity claim with a death claim: a POA confers administrative authority only during the owner's lifetime; once the annuitant dies, the death claim process applies, requiring beneficiary Chloe to submit proof of death, and because market value is below the adjusted death guarantee, the higher adjusted guarantee must be paid rather than the lower market value.

c. ✗ Incorrect. A death claim strictly requires legal proof of death such as a death certificate or Attending Physician's Statement (APS) (only maturity claims do not require a death certificate), and prior lifetime withdrawals have proportionally reduced the death guarantee base.

d. ✗ Incorrect. A partial withdrawal only proportionally reduces the guarantee base without voiding a valid beneficiary designation; an estate representative (executor or administrator) claims only if no living eligible beneficiary exists.

181 answer a

a. ✓ Correct. A joint and last survivor annuity designates a primary annuitant and a co–annuitant; upon the death of the first annuitant (Harold), the surviving co–annuitant (Irene) becomes the sole annuitant and continues receiving annuity payments. The beneficiary (Kevin) is entitled to receive remaining guaranteed payments only after the second annuitant dies, provided that death occurs within the 15–year guarantee period.

b. ✗ Incorrect. Falls into the trap of paying the beneficiary upon the first death in a joint annuity. In a joint and last survivor annuity, as long as the co–annuitant Irene is living, the death of the first annuitant does not trigger a payout to the beneficiary; remaining guaranteed payments pass to the beneficiary only if the second annuitant also dies within the guarantee period.

c. ✗ Incorrect. After the first annuitant dies, the surviving co–annuitant Irene becomes the sole annuitant receiving full ongoing annuity payments, leaving beneficiary Kevin with no claim rights at this time.

d. ✗ Incorrect. Confuses a joint and last survivor annuity with a single life annuity having no guarantee period. A joint and last survivor annuity continues payments to the surviving co–annuitant until their death.

181′ answer d

a. ✗ Incorrect. A 75% guarantee is a guarantee mechanism of segregated funds (IVICs) and does not apply to traditional payout annuities; a single life annuity with no guarantee period or refund option provides no death benefit once the annuitant dies.

b. ✗ Incorrect. A single life annuity with no guarantee period and no death refund option provides no beneficiary claim rights, terminating payments immediately upon the annuitant's death with zero death benefit.

c. ✗ Incorrect. The length of a guarantee period is set by the contract (10 years in Contract 2) rather than expiring after 5 years; because both annuitants in Contract 2 died in Year 7, within the 10–year guarantee period, the beneficiary is entitled to the remaining 3 years of guaranteed payments.

d. ✓ Correct. A single life annuity with no guarantee period and no death refund option (Contract 1) yields no death benefit following the annuitant's death; in contrast, under a joint and last survivor annuity (Contract 2), when the second annuitant dies within the 10–year guarantee period (Year 7), the named beneficiary is entitled to claim the remaining balance of guaranteed payments.

182 answer c

a. ✗ Incorrect. Falls into the broad POA beneficiary changes trap. Exam guidance explicitly warns that authority to sign an application does not confer authority to designate or change beneficiaries, and BC Power of Attorney Act s. 20 strictly restricts an attorney under an enduring POA from altering existing beneficiary designations.

b. ✗ Incorrect. Although applications generally require the owner's personal signature, representation by an attorney acting under a valid Power of Attorney for property constitutes a recognized legal signing exception allowing the attorney to sign.

c. ✓ Correct. Accurately reflects both exam guidance and current BC law: on one hand, an attorney under a valid POA may sign a segregated fund application, but whether they have the authority to designate a beneficiary requires separate legal advice; on the other hand, under BC Power of Attorney Act s. 20, an attorney under an enduring POA cannot change an existing beneficiary designation without court authorization, may retain the original beneficiary only when renewing or replacing a similar instrument under qualifying conditions, and is restricted to designating the adult's estate on newly created instruments.

d. ✗ Incorrect. A reason–why letter is simply the advisor's written confirmation of their needs analysis findings, which is neither underwriting proof nor contract validation, and certainly cannot substitute for the court authorization mandated by BC Power of Attorney Act s. 20.

182′ answer b

a. ✗ Incorrect. Falls into the trap of assuming a POA in BC can freely alter beneficiaries. BC Power of Attorney Act s. 20 imposes strict conditions on attorneys under enduring powers of attorney, expressly barring them from naming new family members as beneficiaries without court authorization.

b. ✓ Correct. Under BC Power of Attorney Act s. 20: an attorney under an enduring POA cannot alter an existing beneficiary designation without court authorization; when renewing, replacing, or converting a similar instrument, they may retain the same beneficiary designated while the adult was capable under statutory conditions; and when creating a brand–new instrument, any new designation is limited strictly to the adult's estate.

c. ✗ Incorrect. An attorney under a POA must act strictly in the adult's best interests and is prohibited from changing or creating beneficiary designations in favor of themselves without court authorization.

d. ✗ Incorrect. An attorney under a valid POA is legally authorized to sign segregated fund applications on the adult's behalf, and doing so does not cause the contract to lose its death benefit guarantee.

Chapter 27 answers and reasons

183 answer a

a. ✓ Correct. For pension plans governed by the Pension Benefits Standards Act (PBSA), the legal plan administrator holds a fiduciary duty and must adhere to the prudent person rule to act in the best interests of plan members and beneficiaries; even when outsourcing day–to–day investment management to an insurer, the legal administrator cannot be relieved of its supervisory responsibility.

b. ✗ Incorrect. Falls into the outsourcing relieves liability trap. The prudent person rule binds the legal administrator in its role as a fiduciary; delegating day–to–day operations to a service provider does not transfer the administrator's statutory supervisory responsibility.

c. ✗ Incorrect. Falls into the employee investment choice eliminates employer liability trap. Even though members select their own funds in a DCPP, the administrator must still fulfill fiduciary duties in selecting and monitoring service providers, designing the investment menu, and communicating with members.

d. ✗ Incorrect. The distribution structure for group retirement plans typically connects the agent, plan sponsor, and insurer group specialists directly; the exam standard does not feature a managing general agent (MGA), and an MGA is certainly not a statutory fiduciary administrator under pension legislation.

183′ answer c

a. ✗ Incorrect. While an insurer is responsible for regularly submitting financial reports to the sponsor, this does not relieve the legal administrator of its ongoing supervisory duty under the prudent person rule.

b. ✗ Incorrect. Whether a plan is a DBPP or a DCPP, the legal administrator of a pension plan governed by the PBSA owes an ongoing fiduciary duty.

c. ✓ Correct. As a fiduciary, the legal plan administrator must adhere to the prudent person rule to act in the best interests of plan members and beneficiaries; delegating day–to–day administration cannot relieve the administrator of its supervisory duty.

d. ✗ Incorrect. Members are participating employees; the statutory duty to supervise the insurer lies with the plan administrator, not individual employees.

184 answer b

a. ✗ Incorrect. Funds within a Deferred Profit Sharing Plan (DPSP) are not locked in and are not subject to the pension locking–in rules of the PBSA.

b. ✓ Correct. A Deferred Profit Sharing Plan (DPSP) is strictly non–contributory by law, permitting contributions solely from the sponsor out of current or retained profits, and employees cannot contribute; furthermore, individuals who own 10% or more of voting shares or are related to the employer are barred from participating.

c. ✗ Incorrect. A DPSP and a DCPP are not mutually exclusive; an employer can maintain a DCPP as a foundational fixed–contribution plan and layer a DPSP on top as a profit–sharing incentive.

d. ✗ Incorrect. Employer contributions to a DPSP do not constitute current taxable income to employees (they accumulate pre–tax until fully taxed upon withdrawal); employer contributions that constitute current taxable benefits are those made to a GRRSP or Group TFSA.

184′ answer a

a. ✓ Correct. A DCPP and a Deferred Profit Sharing Plan (DPSP) can coexist: the DCPP provides a stable baseline contribution commitment, while the non–contributory DPSP funded solely by the employer from profits serves as a flexible incentive layer that can suspend contributions in non–profitable years per plan terms; eligible employees excludes those owning 10% or more of shares and related persons.

b. ✗ Incorrect. Falls into the contributory DPSP trap. A DPSP is strictly non–contributory by law and never allows employees to contribute 5% of their own funds.

c. ✗ Incorrect. Inverts the risk structure of a DBPP: under a DBPP, the sponsor must actuarially fund any investment shortfall, increasing financial pressure on the employer during market downturns.

d. ✗ Incorrect. Employees holding 10% or more of voting shares (as well as individuals related to the employer) are legally barred from participating in a DPSP.

185 answer c

a. ✗ Incorrect. Falls into the trap of confusing which plans generate a PA. DBPP, DCPP, and DPSP all generate a Pension Adjustment (PA); plans that do not generate a PA are GRRSP, PRPP, and Group TFSA.

b. ✗ Incorrect. Falls into the trap of assuming a PA includes only employer contributions. For a DCPP, the current-year PA equals total contributions from both employer and employee (5% + 5% = 10%, or $8,000), not merely the employer's portion.

c. ✓ Correct. Total DCPP contributions for the year are $80,000 × 10% (5% employer + 5% employee) = $8,000, which forms the current-year Pension Adjustment (PA). Next year's RRSP limit is $80,000 × 18% = $14,400; after deducting the $8,000 PA, the employee has $6,400 of remaining personal RRSP contribution room.

d. ✗ Incorrect. The $14,400 figure is the baseline RRSP limit calculated at 18% before deductions, not her actual total DCPP contribution of $8,000 for the year.

185′ answer b

a. ✗ Incorrect. Falls into the common misconception of treating a GRRSP and an individual RRSP as two separate limits. A Group RRSP (GRRSP) and an individual RRSP share the exact same annual contribution room.

b. ✓ Correct. A GRRSP does not generate a Pension Adjustment (PA), but directly consumes current-year RRSP contribution room: the maximum RRSP room for the year is $60,000 × 18% = $10,800; subtracting total GRRSP contributions of $6,000 ($60,000 × 5% × 2 from employer and employee), $4,800 remains for personal RRSP contributions.

c. ✗ Incorrect. A GRRSP produces no PA whatsoever; the combined $6,000 contributed by employer and employee to the GRRSP directly consumes his RRSP contribution room in the current year.

d. ✗ Incorrect. Falls into the universal PA coverage illusion. Because GRRSP contributions directly reduce current-year RRSP room, they never generate a PA to double-deduct from next year's room (only DBPP, DCPP, and DPSP generate a PA).

186 answer d

a. ✗ Incorrect. Employer contributions to a Defined Contribution Pension Plan (DCPP) are not current taxable income to the employee, remaining tax-deferred until withdrawn in retirement; registered pension status does not make them currently taxable.

b. ✗ Incorrect. Employer contributions to a DPSP and a PRPP are not included in the employee's current taxable income (they accrue pre-tax and are taxed only upon withdrawal).

c. ✗ Incorrect. Falls into the tax-free employer contribution illusion. Employer contributions to a GRRSP and a Group TFSA must be included as current taxable benefits to the employee in the year contributed.

d. ✓ Correct. Among group plans, employer contributions to a Group RRSP (GRRSP) and a Group TFSA are considered current taxable benefits (treated as additional salary); while the employee receives an offsetting RRSP tax deduction for GRRSP contributions, both items must be reported separately. Among the four options, only the GRRSP falls into this category; employer contributions to a DCPP, DPSP, and PRPP are not current taxable income.

186′ answer a

a. ✓ Correct. Employer contributions to a Group TFSA are treated as current taxable employment income (after–tax contributions equivalent to regular wages), while future withdrawals are completely tax–free; conversely, employer contributions to a DCPP are not current taxable income.

b. ✗ Incorrect. Falls into the trap of assuming all employer contributions are exempt from current tax. A Group TFSA is funded with after–tax dollars, meaning employer contributions must be included in the employee's current taxable benefits.

c. ✗ Incorrect. Completely reverses the tax effects: employer contributions to a DCPP are non–taxable currently, whereas TFSA contributions provide no tax deduction and employer contributions must be reported as current taxable income.

d. ✗ Incorrect. Employer contributions to a DCPP are not currently taxable, and a Group TFSA never generates a Pension Adjustment (PA).

187 answer b

a. ✗ Incorrect. Both reverses the master–then–individual application sequence and mistakenly introduces a managing general agent (MGA) retail intermediary tier (group plans typically connect the agent, plan sponsor, and insurer group specialists directly).

b. ✓ Correct. In group plans, the agent's client is the plan sponsor, and under Treating Customers Fairly (FTC) principles the agent must disclose representing insurers, compensation methods, and conflicts of interest directly to the sponsor; the implementation follows a two–stage process where the sponsor applies first to establish the master contract, and individual members submit enrolment and beneficiary forms after insurer underwriting approval.

c. ✗ Incorrect. A group plan is not a one–time transaction; when a sponsor experiences material changes such as large–scale hiring, layoffs, or insolvency, the agent has an ongoing duty to review and assist in adjusting the plan design.

d. ✗ Incorrect. Disclosing compensation arrangements and potential conflicts of interest to the plan sponsor is a statutory professional obligation of the agent and cannot be withheld on grounds of confidentiality.

187′ answer c

a. ✗ Incorrect. A triennial assessment every three years is the administrator's statutory requirement for filing with the regulator, whereas agent follow–up on major workforce changes is an ongoing service responsibility that cannot be deferred.

b. ✗ Incorrect. Group plan distribution generally does not involve an MGA, and an agent has no legal authority to freeze vested employee account entitlements.

c. ✓ Correct. Step four in the agent's practical workflow is annual review and notification of changed circumstances: when significant workforce expansion, layoffs, or insolvency events occur, the agent is obligated to promptly report the change and assist in modifying the plan design.

d. ✗ Incorrect. The master plan application is executed by the plan sponsor; individual employees complete member–level enrolment and beneficiary designation forms and are not required to resubmit master contract applications.

188 answer a

a. ✓ Correct. Locked-in funds from a DCPP transferred into a Life Income Fund (LIF) remain governed by pension locking-in rules, subjecting annual withdrawals to both statutory minimum and maximum limits (to prevent exhausting funds prematurely); conversely, unlocked funds from a DPSP or GRRSP transferred into a RRIF are subject only to an annual minimum withdrawal limit with no maximum cap.

b. ✗ Incorrect. Confuses locked-in income vehicles with unlocked income vehicles: only a LIF holding locked-in funds enforces an annual maximum withdrawal limit, whereas a RRIF has no maximum limit.

c. ✗ Incorrect. The account designed to hold locked-in funds for self-directed investment without generating immediate income is a Locked-in Retirement Account (LIRA), whereas a LIF is specifically designed to provide retirement income within annual minimum and maximum limits.

d. ✗ Incorrect. Falls into the trap of confusing vesting with unlocking. Vesting means the employee owns the benefit, but does not unlock the funds; locked-in DCPP assets cannot be transferred directly into an unlocked RRIF without withdrawal caps.

188′ answer d

a. ✗ Incorrect. Falls into the termination unlocks funds trap. DCPP assets are locked in and cannot be transferred to a standard unlocked individual RRSP upon termination.

b. ✗ Incorrect. A RRIF receives unlocked funds (such as from a GRRSP, DPSP, or individual RRSP) and is an income payout vehicle, failing both the locked-in requirement and his objective of deferring retirement income.

c. ✗ Incorrect. Locked-in pre-tax pension assets from a DCPP cannot be transferred tax-free into an after-tax TFSA, nor does any such unlocking mechanism exist.

d. ✓ Correct. A Locked-in Retirement Account (LIRA) is specifically designed to receive locked-in funds transferred from a DCPP or PRPP, allowing the individual to manage investments independently away from the former employer's menu while deferring retirement income.

189 answer c

a. ✗ Incorrect. Triggers two traps simultaneously: first, a Defined Benefit Pension Plan (DBPP) is explicitly excluded from being a Capital Accumulation Plan (CAP); second, group segregated funds do not offer default death benefit guarantees.

b. ✗ Incorrect. The criterion for determining a CAP is whether members have investment choice, not whether the employer contributes; furthermore, group segregated funds do not provide default death benefit guarantees.

c. ✓ Correct. The core criterion for a Capital Accumulation Plan (CAP) is that members can choose among two or more investment options (excluding a DBPP); additionally, despite segregated funds having guarantee features in retail markets, group segregated funds generally carry no default death benefit guarantee.

d. ✗ Incorrect. Any plan permitting members to choose among two or more investment options (such as a DCPP, GRRSP, DPSP, or PRPP) constitutes a CAP, not solely a Group TFSA; furthermore, group segregated funds simply omit death benefit guarantees by default rather than requiring medical underwriting to add them.

189′ answer b

a. ✗ Incorrect. Falls into the trap of misclassifying a DBPP as a CAP based on its defined benefit structure. Because a DBPP offers no individual investment choice to members, it does not qualify as a Capital Accumulation Plan (CAP).

b. ✓ Correct. A plan where members can select among two or more investment options (excluding a DBPP) constitutes a Capital Accumulation Plan (CAP), though group segregated funds offered within such plans generally carry no death benefit guarantee.

c. ✗ Incorrect. Falls into the trap of assuming all segregated funds include death benefit guarantees. Group segregated funds generally provide no default death benefit guarantee.

d. ✗ Incorrect. A CAP is specifically a classification for group retirement and savings plans where members make choices among two or more investment options.

Chapter 28 answers and reasons

190 answer b

a. ✗ Incorrect. Falls into the assuming an unlicensed assistant only booking appointments commits no violation trap. Statutory licensing requirements are not limited to signing applications or giving advice; soliciting insurance, preparing life insurance illustrations, and forwarding applications all legally require an insurance license.

b. ✓ Correct. Agency employees who solicit insurance (including telephoning prospects to book insurance discussions), receive or forward applications and policies, collect premiums, or prepare life insurance policy illustrations must be licensed; furthermore, unsolicited calls to prospective clients must comply with National Do Not Call List (DNCL) rules.

c. ✗ Incorrect. An unlicensed assistant telephoning prospective clients to schedule insurance appointments constitutes unlicensed solicitation, and forwarding applications is likewise an activity that strictly requires a license.

d. ✗ Incorrect. Switching to bulk commercial emails does not circumvent unlicensed solicitation prohibitions and additionally triggers mandatory consent and unsubscribe mechanism requirements under Canada's Anti–Spam Legislation (CASL).

190′ answer c

a. ✗ Incorrect. An insurance agency is permitted to employ purely administrative personnel; the violation arises from assigning unlicensed staff activities that legally require a license, rather than a blanket ban on hiring administrative staff.

b. ✗ Incorrect. Both independent agents and captive agents are permitted to collect premiums and prepare illustrations, provided they are properly licensed and authorized under their agency contracts.

c. ✓ Correct. The exam standard specifies that agency employees who solicit insurance, receive applications, negotiate or effect insurance, forward applications or policies, collect premiums, or prepare life insurance illustrations must hold an insurance license.

d. ✗ Incorrect. Having two corporate officers sign is a standard signing authority requirement when a corporation applies for a policy, which is irrelevant to collecting premium cheques; moreover, agent licensing is governed by the Financial Institutions Act rather than the Insurance Act.

191 answer a

a. ✓ Correct. The law sets no maximum age at which capacity is presumed lost, so a 100–year–old who understands policy terms and the binding nature of the contract is presumed to possess legal capacity; furthermore, under BC Insurance Act s.72, anyone aged 16 or older has the legal capacity to contract for insurance on their own life, even though BC's age of majority is 19.

b. ✗ Incorrect. Falls into the presuming elderly individuals lack contracting capacity trap. There is no statutory upper age limit for capacity, and an agent cannot arbitrarily demand family co–signatures based solely on age; additionally, the age of majority in British Columbia is 19, not 16.

c. ✗ Incorrect. Having parents apply on a minor's behalf based on insurable interest applies to children aged 15 and under; individuals aged 16 or older (including 17–year–olds) possess statutory capacity to contract for life insurance on their own lives under s.72.

d. ✗ Incorrect. Arthur is mentally sharp and retains legal capacity, while Chloe is 16 or older and has statutory contracting capacity; neither requires a representation agreement or intervention by the Public Guardian and Trustee.

191′ answer d

a. ✗ Incorrect. The statutory minimum age to contract for insurance on one's own life is strictly age 16 under s.72; minors aged 15 and under must have a policy applied for on their behalf by a parent who holds an insurable interest.

b. ✗ Incorrect. Falls into the interchanging age numbers trap. The age of majority in British Columbia is 19 (unlike Alberta and Ontario where it is 18); moreover, minors aged 16 or older can purchase insurance on their own lives, and children aged 15 or under can be insured by their parents.

c. ✗ Incorrect. BC Insurance Act s.72 grants a 16–year–old capacity to contract for insurance on their own life, but explicitly excludes the capacity to receive insurance money directly as a beneficiary; directly collecting proceeds and giving a valid discharge requires reaching age 18 under s.88(4).

d. ✓ Correct. Children aged 15 and under can be insured by a parent who holds an insurable interest; under s.72, a 16–year–old has statutory capacity to purchase insurance on her own life, but lacks the legal capacity to receive death proceeds directly as a beneficiary and give a valid discharge (which requires reaching age 18, otherwise proceeds are paid to a trustee or the Public Guardian and Trustee under s.88).

192 answer c

a. ✗ Incorrect. Insurable interest and written consent are not conjunctive requirements that must both exist simultaneously; BC Insurance Act s.45(2) explicitly provides that the written consent of the insured serves as a valid statutory exception when insurable interest is lacking.

b. ✗ Incorrect. The Insurance Council of BC licenses insurance agents and does not adjudicate insurable interest on individual policies; furthermore, the adult status of the insured does not require regulatory pre–approval under the s.45(2) written consent exception.

c. ✓ Correct. Under BC Insurance Act s.45(1), a contract is void if the applicant lacks an insurable interest in the insured at the time the contract takes effect; however, s.45(2) expressly exempts group insurance and contracts where the proposed insured consents in writing to the coverage.

d. ✗ Incorrect. The two–year incontestability provision under s.52 addresses innocent misrepresentation or non–disclosure; it cannot validate a contract that is void ab initio for lacking both an insurable interest and written consent.

192′ answer a

a. ✓ Correct. Under BC Insurance Act s.45(2) and s.45(3), when an applicant lacks an insurable interest, a contract takes effect if the insured consents in writing; where the proposed insured is under 16 years of age, written consent may be validly granted by a parent or a person standing in the place of a parent.

b. ✗ Incorrect. A minor under 16 years of age lacks the statutory capacity to grant written consent independently under s.45(2); consent must be provided by a parent or person standing in the place of a parent under s.45(3).

c. ✗ Incorrect. While insuring for criminal purposes such as arson violates public policy and renders a contract void, insuring a minor under 16 with the written consent of a parent is an express statutory exception authorized by Insurance Act s.45(3).

d. ✗ Incorrect. A 15–year–old minor cannot execute a Power of Attorney to substitute for parental consent under s.45(3), and BCFSA does not register policy consent forms.

193 answer d

a. ✗ Incorrect. Falls into the assuming holding a Power of Attorney permits changing beneficiaries directly trap. Acting before receiving verified documentation is a severe compliance violation; an ordinary Power of Attorney terminates upon the donor's mental incapacity, uncertified photocopies cannot be accepted, and an attorney cannot arbitrarily redirect policy proceeds to themselves.

b. ✗ Incorrect. A Representation Agreement under the Representation Agreement Act (c. 405) primarily covers personal care, healthcare decisions, and routine financial management (s.7); it does not provide blanket authority to alter major life insurance beneficiaries and can never bypass insurer review.

c. ✗ Incorrect. Both the Power of Attorney Act s.21 and the Representation Agreement Act s.19.01 strictly prohibit an attorney or representative from making a will on behalf of the adult.

d. ✓ Correct. The exam standard requires a four-step workflow: first, confirm whether the document is an Enduring Power of Attorney that remains valid after incapacity; second, obtain a notarized certified true copy; third, submit it to the insurer for review; and fourth, determine whether the requested instruction can be executed. While the exam notes interprovincial variations, BC Power of Attorney Act s.20 mandates court authorization before an attorney can alter the donor's existing beneficiary designations.

193′ answer b

a. ✗ Incorrect. Falls into the mistaking an ordinary PoA for an enduring PoA trap. An ordinary Power of Attorney automatically terminates once the donor loses mental capacity; only an Enduring PoA explicitly drafted to survive incapacity remains valid.

b. ✓ Correct. The ordinary Power of Attorney terminated when the donor became mentally incapable; furthermore, the exam curriculum explains that the core policy objective behind restricting beneficiary changes is to prevent an attorney from indirectly revoking the donor's original designation simply by transferring funds from one financial institution to another. (Note: While the exam notes BC as an exception, BC Power of Attorney Act s.20 requires court authorization to alter existing designations, permits renewing similar instruments retaining the original beneficiary under specific conditions, and limits new designations to the donor's estate).

c. ✗ Incorrect. An ordinary PoA terminates upon incapacity and never converts into a will; furthermore, attorneys are strictly prohibited by law from executing a will on the donor's behalf under s.21.

d. ✗ Incorrect. The exam curriculum warns agents to avoid acting as an attorney, executor, or trustee for clients due to inherent conflicts of interest, and professional Errors and Omissions (E&O) insurance generally does not cover outside property management activities.

194 answer a

a. ✓ Correct. Under BC Insurance Act s.59 and s.61, a subsequent valid beneficiary designation takes precedence over an earlier designation; the separation agreement binds David personally but does not bind an insurer that never received notice. Under s.77, paying the recorded beneficiary (the new spouse) before receiving written notice of a competing claim at its head or principal office fully discharges the insurer, leaving the former spouse to seek recourse against David's estate.

b. ✗ Incorrect. Falls into the assuming a separation agreement automatically locks policy beneficiaries trap. An irrevocable designation under s.60 must be executed in statutory form and filed with the insurer's principal office while the insured is living; a privately executed separation agreement does not automatically convert a revocable beneficiary into an irrevocable one.

c. ✗ Incorrect. The five-day survival rule under Wills, Estates and Succession Act s.10 governs simultaneous deaths of beneficiaries/heirs (and s.11 expressly excludes insurance proceeds governed by the Insurance Act); it has no application to competing claims between successive spouses.

d. ✗ Incorrect. As long as a policy validly designates a beneficiary (here, the new spouse), death benefit proceeds remain exempt from execution and seizure by the policyholder's creditors under BC Insurance Act s.65.

194′ answer c

a. ✗ Incorrect. An unsigned note does not constitute a valid irrevocable designation, and when adverse claims arise, the insurer applies to pay money into court under s.82 rather than forfeiting funds to BCFSA.

b. ✗ Incorrect. The Canada Health Act governs national standards for public health insurance and is completely irrelevant to life insurance beneficiary designations or claims disputes.

c. ✓ Correct. Under BC Insurance Act s.60(1), an irrevocable beneficiary designation must be filed with the insurer at its head or principal office in Canada while the insured is living, after which the policyowner cannot alter or revoke the designation without that beneficiary's consent; if the insurer admits liability but faces competing adverse claimants, it may apply to pay the proceeds into court under s.82.

d. ✗ Incorrect. Storing physical policy contracts in an agent's cabinet does not legally restrict a policyholder from executing a change of beneficiary directly with the insurer; furthermore, six years is the absolute limitation period for commencing an action following death under s.76.

195 answer b

a. ✗ Incorrect. The two $9,000 cash payments made within 24 hours total $18,000, triggering the mandatory 24-hour aggregation rule for transactions reaching $10,000; additionally, because BC enacted substantially similar private-sector privacy legislation (PIPA), intra-provincial commercial activities are governed by PIPA rather than federal PIPEDA.

b. ✓ Correct. Under the Proceeds of Crime (Money Laundering) and Terrorist Financing Act (PCMLTFA), the threshold for filing a large cash transaction report with FINTRAC is $10,000, subject to a 24-hour aggregation rule where two $9,000 payments totaling $18,000 within 24 hours must be reported by the agent personally; regarding privacy, commercial activities conducted wholly within British Columbia are governed by the provincial Personal Information Protection Act (PIPA).

c. ✗ Incorrect. The exam standard emphasizes that under the PCMLTFA, the legal duty to report suspicious transactions and large cash amounts rests personally on every licensed agent; failure to report exposes the individual agent to severe personal fines and imprisonment.

d. ✗ Incorrect. Falls into the equating provincial insurance regulation with total federal irrelevance trap. While the Constitution allocates insurance contracts to provincial jurisdiction, federal perimeter legislation—including anti-money laundering (PCMLTFA) and cross-border privacy (PIPEDA)—directly regulates life insurance agents.

195′ answer d

a. ✗ Incorrect. Anti-money laundering reporting obligations rest directly on individual agents rather than solely on an insurer's chief compliance officer; additionally, the Representation Agreement Act governs personal care and financial representation, not data privacy.

b. ✗ Incorrect. A suspicious transaction report (STR) has no minimum monetary threshold (and the large cash threshold is $10,000, not the CPP ceiling of $74,600); moreover, BC Insurance Act s.42 prescribes required policy provisions, not privacy rules.

c. ✗ Incorrect. The legal duty to report to FINTRAC falls upon the agent rather than the client self-reporting to BCFSA (the 10-business-day window relates to CASL unsubscribe requests); furthermore, cross-border personal data transfers fall under federal PIPEDA.

d. ✓ Correct. The PCMLTFA places the statutory obligation to report suspicious transactions and terrorist property directly upon the individual agent, with non-compliance carrying severe penalties including imprisonment; while intra-provincial business in BC falls under provincial PIPA, personal data crossing provincial or national borders is governed by federal PIPEDA.

196 answer c

a. ✗ Incorrect. Self-employed individuals are ineligible for regular Employment Insurance (EI) sickness benefits; furthermore, both OAS and GIS are funded from federal general tax revenues rather than payroll deductions, and OAS is taxable while only the GIS is tax-free.

b. ✗ Incorrect. Workers' compensation is an employer-funded provincial no-fault system protecting eligible workers, whereas the CPP is a mandatory contributory program whose retirement benefits are taxable.

c. ✓ Correct. Regular Employment Insurance (EI) requires insurable employment hours, meaning self-employed individuals do not qualify for regular EI (making individual disability coverage essential); Old Age Security (OAS) is a non-contributory pension funded by general tax revenues and is taxable, whereas the Guaranteed Income Supplement (GIS) is a tax-free supplement for low-income seniors.

d. ✗ Incorrect. BC Medical Services Plan (MSP) individual premiums were eliminated on January 1, 2020 (previously up to $1,800 annually per family); additionally, MSP covers medically required physician services, not routine prescription drugs, routine dental care, or eye exams for adults aged 19 to 64.

196′ answer a

a. ✓ Correct. Workers' compensation is an employer-funded, no-fault provincial program under which injured workers surrender their right of action against employers (in BC wage-loss benefits equal approximately 90% of net earnings); coordination of benefits ensures that when spouses each have group plans, claims are adjudicated so the combined payout covers up to 100% of eligible expenses without duplicate reimbursement.

b. ✗ Incorrect. The CPP is a contributory social insurance program funded equally by employee and employer payroll contributions rather than general tax revenues; furthermore, the foundational historic compromise of workers' compensation is that workers surrender the right to sue employers for workplace injuries.

c. ✗ Incorrect. The exam standard clarifies that auto insurance 'no-fault' does not mean fault is never determined, but rather that injured parties claim medical and income benefits from their own insurer; moreover, coordination of benefits rules strictly prohibit double recovery on a single dental expense.

d. ✗ Incorrect. A benefit paying 55% of weekly earnings up to 26 weeks (2026 weekly maximum $729) describes Employment Insurance (EI) sickness benefits; CPP disability benefits require meeting contribution thresholds and having a severe and prolonged disability (2026 monthly maximum $1,741.20).

Chapter 29 answers and reasons

197 answer b

a. ✗ Incorrect. Falls into the mistaking a single milestone for the effective date trap. Although unconditional delivery of a policy as applied for to an authorized agent constitutes delivery under s.48(2), the insurer here modified coverage terms (adding a rating and an exclusion rider), the initial premium had not been paid, and the counter-offer had not been accepted; therefore, no contract was formed on Monday.

b. ✓ Correct. When an issued policy differs from the original application (rated premium, exclusion rider, or reduced face amount), it legally constitutes a counter-offer rather than an acceptance of the applicant's offer; the contract only takes legal effect once the client accepts the counter-offer (signing the acceptance on Friday), combined with delivery, payment of the initial premium, and unchanged insurability.

c. ✗ Incorrect. Falls into the stopping one step short trap. Had the policy been issued as applied for, completing delivery and premium payment on Wednesday with unchanged insurability would have brought coverage into effect under s.48; however, because the insurer modified the terms, the policy was a counter-offer that Noah had not yet formally accepted on Wednesday, leaving the contract unformed.

d. ✗ Incorrect. An application is merely an offer; because no initial premium accompanied the application and no interim insurance was in place, subsequent premium payment and acceptance of a counter-offer do not retroactively backdate coverage to the application date.

197′ answer d

a. ✗ Incorrect. Falls into the mistaking underwriting approval or payment as the sole condition trap. When no premium accompanies the application, taking effect strictly requires policy delivery, initial premium payment, and unchanged insurability between application and delivery under s.48.

b. ✗ Incorrect. An insurer does not automatically append a two-year exclusion rider to make coverage take effect; when insurability changes, the agent cannot complete delivery and must return the policy for underwriting reassessment.

c. ✗ Incorrect. Confirming unchanged health prior to delivery (typically by obtaining a signed statement of good health) is a legal and regulatory requirement rather than a courtesy; knowingly delivering a policy when insurability has changed exposes the agent to regulatory discipline and liability.

d. ✓ Correct. Under the statutory conditions for taking effect in s.48, the applicant's insurability must remain unchanged from the application date until delivery and payment of the initial premium; discovering a nodule and being advised to undergo a biopsy represents a change in insurability, preventing the policy from taking effect as issued until reassessed by underwriting.

198 answer c

a. ✗ Incorrect. Falls into the confusing misstatement of age with health misrepresentation trap, mistakenly assuming both items are adjusted proportionally. Only misstatement of age triggers an adjusted face amount based on true age; smoking status affects the underwriting decision itself and is not subject to proportional adjustment.

b. ✗ Incorrect. Reverses both rules: as long as the true age does not exceed the insurable age limit, an age misstatement under s.54 never voids the contract but instead adjusts the death benefit; conversely, checking non-smoker while smoking weekly cigars is a material misrepresentation that permits the insurer to void the contract within two years even without fraud.

c. ✓ Correct. Age and smoking follow two separate statutory tracks: under s.54, misstatement of age does not void the contract when within insurable age limits, adjusting the payout to what premiums paid would have purchased at the true age; meanwhile, smoking status is a material fact (ss.51, 52), and because death occurred within the two-year contestability window, the insurer may void the policy and refund premiums.

d. ✗ Incorrect. The duty of disclosure under s.51 depends on whether the fact was material to the insurer's underwriting decision or pricing at the time of application; the insurer is not required to prove a direct causal link between the undisclosed fact and the ultimate cause of death.

198′ answer a

a. ✓ Correct. Under the misstatement of age provision in s.54, age is an actuarially determinable pricing variable; as long as the true age does not exceed the insurable age limit, whether discovered within or after two years, the insurer does not void the policy but pays the coverage amount that the premiums paid would have purchased at the true age.

b. ✗ Incorrect. Falls into the applying the two-year incontestability period to age misstatements trap. The incontestability clause in s.52 governs contract rescission, whereas misstatement of age is governed specifically by s.54, which mandates adjusting the coverage amount based on the true age even after two years.

c. ✗ Incorrect. As long as the true age does not exceed the maximum insurable age limit (s.54(3) exception), an age misstatement is not subject to policy rescission, but results in a proportional adjustment of the death benefit.

d. ✗ Incorrect. The statutory remedy for a misstatement of age is adjusting the insurance amount (paying what the premium buys at the true age) rather than maintaining the face amount and deducting back premiums with interest (deducting overdue premiums applies to deaths during the grace period).

199 answer a

a. ✓ Correct. The incontestability provision in s.52 only protects innocent or non–fraudulent misrepresentation after a policy has been in force for two years during the insured's lifetime; deliberately omitting medical history constitutes fraud, which vitiates the foundation of utmost good faith and is never protected by the two–year incontestability period.

b. ✗ Incorrect. Falls into the assuming the incontestability period protects fraud trap. Seeing that three years have elapsed leads candidates to assume the incontestability clause is an absolute shield, overlooking that the stem specifies Chloe deliberately omitted the diagnosis, which denotes fraud.

c. ✗ Incorrect. Falls into the confusing misstatement of age with health fraud trap. Proportionally adjusting the coverage amount applies only to misstatements of age under s.54; deliberately concealing a serious medical condition is fraudulent misrepresentation, which allows the insurer to void the contract rather than adjust the benefit.

d. ✗ Incorrect. The sixty days from discovery within five years of issue timeframe is a specific statutory rule for voiding a contract when a true age exceeds the maximum insurable limit under s.54(3); it has no application to fraud exceptions under incontestability.

199′ answer c

a. ✗ Incorrect. Overlooks the protective function of the two–year incontestability provision in s.52: to prevent insurers from challenging policies after death over honest oversights from years earlier, non–fraudulent misrepresentations no longer render the contract voidable once in force for two years.

b. ✗ Incorrect. Omitting medical history does not fall under the benefit adjustment rules for misstatement of age under s.54.

c. ✓ Correct. Under the incontestability provision in s.52, where a policy has been in force during the lifetime of the insured for two years, non–fraudulent non–disclosure or misrepresentation (an innocent oversight) no longer renders the contract voidable, and the insurer must pay the claim in full.

d. ✗ Incorrect. After two years in force, non–fraudulent misrepresentations satisfying s.52 unconditionally cease to render the policy voidable, rather than shifting the legal burden of proof onto the beneficiary.

200 answer d

a. ✗ Incorrect. Falls into the assuming divorce automatically revokes an irrevocable designation trap. Divorce itself does not automatically terminate or convert an irrevocable beneficiary designation.

b. ✗ Incorrect. Falls into the assuming a general waiver in a separation agreement directly binds the insurer trap. A separation agreement is a private inter–spousal contract to which the insurer is not a party; without a specific written consent or release delivered to the insurer's head office, it cannot alter policy rights (ss.60(1), 77).

c. ✗ Incorrect. Once an irrevocable designation takes effect, actions that reduce or jeopardize policy values—such as surrenders, cash withdrawals, or policy loans—strictly require the written consent of the irrevocable beneficiary under s.66(1) and Regulation s.9.1(5).

d. ✓ Correct. Once an irrevocable beneficiary designation takes effect upon head office delivery under s.60(1), changing the beneficiary and taking out a policy loan that reduces policy proceeds under s.66(1) both require the irrevocable beneficiary's written consent; divorce does not automatically revoke the designation, so Sofia must execute a written consent or release delivered to the insurer's head office.

200′ answer b

a. ✗ Incorrect. Under both the national exam standard and BC Insurance Act s.60(1), an irrevocable beneficiary designation must be filed with the insurer at its head or principal office in Canada during the lifetime of the life insured to take legal effect.

b. ✓ Correct. Under the statutory requirements for an irrevocable designation in s.60(1) and national exam standards, an irrevocable designation only takes effect once filed with the insurer's head or principal office during the insured's lifetime; because the form remained in Maya's safe, the designation remained revocable, allowing Maya to change the beneficiary without her sister's consent.

c. ✗ Incorrect. Siblings do not belong to the preferred family class (which is restricted to spouse, children, grandchildren, and parents under s.65(2)); furthermore, even for preferred beneficiaries, revocable designations can be altered unilaterally by the policyholder without locking in rights.

d. ✗ Incorrect. A policyholder may legally name any person other than themselves as an irrevocable beneficiary; the reason sisterly consent is not required here is solely that the irrevocable declaration was never delivered to the insurer's head office.

201 answer b

a. ✗ Incorrect. Falls into the overlooking that reinstatement restarts exclusionary periods trap, assuming reinstatement turns the clock back six years. Reinstatement causes both the incontestability period and the suicide exclusion period to restart from the reinstatement date.

b. ✓ Correct. Reinstatement under s.57 does not roll back the clock, but starts a fresh clock: both the two-year incontestability period and the suicide exclusion period (standard two-year exam benchmark, and BC s.56(2) restarting the contractual period from the most recent reinstatement) run anew from the reinstatement date; because suicide occurred one year after reinstatement, it falls within the restarted two-year exclusion, and the death benefit is denied.

c. ✗ Incorrect. The suicide clause does not prorate coverage based on elapsed time; death by suicide within the exclusion period completely excludes payment of the insurance death benefit.

d. ✗ Incorrect. Falls into the absolute wording trap by asserting policy lapse permanently excludes suicide. Reinstatement merely restarts the two-year (or contractual) exclusion period rather than permanently barring suicide claims.

201′ answer a

a. ✓ Correct. Under the grace period rules in s.50, an overdue premium has a minimum 30-day grace period (28 days for industrial insurance) during which coverage remains in full force; if the life insured dies during the grace period, the insurer pays the death benefit after deducting the overdue premium.

b. ✗ Incorrect. A common misconception assumes the policy is suspended or lapsed during the grace period; coverage remains fully in force throughout the grace period and only lapses if the premium remains unpaid at the end of the 30 days.

c. ✗ Incorrect. The grace period provides a payment buffer while maintaining coverage, but does not waive the premium; the insurer deducts the overdue premium from the death benefit payout.

d. ✗ Incorrect. Submitting evidence of insurability is required to reinstate a policy that has lapsed under s.57; on the 15th day following the premium due date, the policy was within the 30-day grace period and had not lapsed.

202 answer c

a. ✗ Incorrect. Under both the national exam standard and practical insurance rules, a bank cannot obtain first priority over an irrevocable beneficiary to death proceeds without that beneficiary's consent.

b. ✗ Incorrect. A bank loan requires a collateral assignment rather than an absolute assignment, and a policyholder cannot extinguish an irrevocable beneficiary's rights through a unilateral absolute assignment.

c. ✓ Correct. Under the national exam standard, when a policy has an irrevocable beneficiary, executing a collateral assignment requires the irrevocable beneficiary's written consent filed with the insurer for the bank to have first priority over unpaid loan balances at death (e.g., paying $120,000 to the bank first and the remaining $380,000 to the mother). (Note: Current BC Regulation s.9.1(4)(e) and s.66(3) permit executing the assignment without consent, but without consent the bank's interest ranks behind the irrevocable beneficiary; thus granting the bank priority still requires the mother's written consent).

d. ✗ Incorrect. An irrevocable designation does not permanently bar pledging a policy as loan collateral; as long as the irrevocable beneficiary signs a written consent delivered to the insurer, a collateral assignment can proceed.

202′ answer d

a. ✗ Incorrect. Confuses a collateral assignment with an absolute assignment; under a collateral assignment, the lender holds only a limited security interest with priority up to the unpaid loan balance.

b. ✗ Incorrect. The bank's priority claim at death is limited to the unpaid loan balance at death ($120,000), rather than the original loan principal borrowed ($180,000).

c. ✗ Incorrect. Because the irrevocable beneficiary provided written consent and the collateral assignment was properly filed, the bank's security interest has priority over the beneficiary's claim.

d. ✓ Correct. Under a collateral assignment executed with the irrevocable beneficiary's written consent, when the life insured dies, the insurer first pays the outstanding loan balance of $120,000 to the bank, and distributes the remaining $380,000 to the designated beneficiary.

203 answer a

a. ✓ Correct. Naming a spouse (who belongs to the preferred family class of spouse, child, grandchild, or parent under s.65(2)) originally provided two tiers of protection: lifetime policy exemption from seizure and death benefit exemption from the policyholder's creditors under s.65(1); changing the beneficiary to "my estate" forfeits both exemptions, routing the death benefit into probate where it incurs probate fees and becomes fully exposed to Arthur's creditors.

b. ✗ Incorrect. Falls into the assuming protection remains after naming the estate trap. Whenever proceeds are made payable to an estate rather than designated directly to a beneficiary in the contract or declaration, the money enters the estate and is exposed to estate creditors; testamentary distribution under a will cannot restore Insurance Act creditor immunity.

c. ✗ Incorrect. The law does not prohibit a policyholder from naming their own estate (or revoking an existing designation so proceeds fall to the estate); however, doing so forfeits creditor protection and triggers probate costs, consequences an agent must explain beforehand.

d. ✗ Incorrect. Only naming a designated beneficiary outside the estate allows death proceeds to bypass probate; proceeds payable to an estate must pass through probate administration and are included in calculating probate fees.

203′ answer b

a. ✗ Incorrect. A policyholder naming itself to receive proceeds (such as a corporation as policyholder collecting proceeds) does not qualify as a beneficiary under statutory definitions, receiving no beneficiary creditor protection; furthermore, lifetime exemption from seizure strictly requires designating a preferred family class beneficiary.
b. ✓ Correct. A daughter belongs to the preferred family class of beneficiaries (spouse, child, grandchild, parent under s.65(2)), which exempts the policy from execution and seizure by the policyholder's creditors during his lifetime (assuming no fraudulent conveyance); in contrast, under the corporate policy, the corporation collects as policyholder rather than a statutory beneficiary, enjoying no creditor immunity under s.65.
c. ✗ Incorrect. On the contrary, when a corporate policyholder receives proceeds, it collects as policyholder rather than as a statutory beneficiary, enjoying zero creditor exemption under s.65.
d. ✗ Incorrect. Lifetime exemption from seizure under s.65(2) applies both to irrevocable beneficiaries and to revocable designations within the preferred family class (spouse, child, grandchild, parent).

Chapter 30 answers and reasons

204 answer b

a. ✗ Incorrect. Falls into the assuming an insurer is obligated to proactively notify beneficiaries and confusing start dates traps. The exam standard clearly states that an insurer has no duty to proactively notify the beneficiary upon receiving notice of death (it typically contacts the deceased's agent); furthermore, the 30–day payment clock under s.73 begins on the date all four items of sufficient proof of claim are received, rather than from the date of death.
b. ✓ Correct. Upon receiving notice of death, the insurer records the death, stops billing premiums, and awaits a claim, having no duty to actively notify the beneficiary; once all four items of sufficient proof of claim required by s.73 are submitted, the client–protecting 30–day payment clock begins; concurrently, the insurer–protecting limitation period under s.76 requires any legal action to be commenced within the earlier of 2 years after submitting proof or 6 years after death.
c. ✗ Incorrect. Falls into the misapplying statutory provisions trap. The requirements of written notice within 30 days and proof of claim within 90 days are statutory conditions for individual Accident and Sickness (A&S) insurance; life insurance does not have these independent statutory calendar–day deadlines.
d. ✗ Incorrect. Falls into the interpreting no deadline for filing a claim as an unlimited right to sue trap. While filing a claim has no fixed statutory deadline, the statutory limitation period under s.76 for suing the insurer for insurance money is strict, requiring action within the earlier of 2 years after proof is submitted or 6 years after death.

204′ answer d

a. ✗ Incorrect. Assuming a death certificate alone completes proof of claim is a common misconception. BC Insurance Act s.73 requires all four items of proof (the insured event, the insured's age, the claimant's right to receive payment, and the beneficiary's name and age) to be satisfactorily furnished; particularly with term life insurance, the insurer must verify that the insured had not exceeded the policy expiry age.

b. ✗ Incorrect. The statutory payment period for life insurance is 30 days after receiving all four items of proof under s.73, not 60 days; furthermore, the limitation period under s.76 is the earlier of 2 years after proof is submitted or 6 years after death, not 6 years after proof.

c. ✗ Incorrect. Payment into court under s.82 applies to situations such as competing adverse claimants; when documentation is missing, the insurer simply requests the missing proof or, if disputed, applies under s.78 for a declaration as to sufficiency of proof; additionally, 15 days is the deadline for providing claim forms in A&S insurance.

d. ✓ Correct. All four proof of claim hurdles under s.73 (the insured event, the insured's age, the claimant's right to receive payment, and the beneficiary's name and age) are mandatory; only when all four are received does the 30-day payment clock begin; the deadline for filing a lawsuit is governed by s.76, which mandates the earlier of 2 years after proof is submitted or 6 years after death.

205 answer c

a. ✗ Incorrect. Falls into the seven-year disappearance threshold and policy lapse trap. When sufficient circumstantial evidence exists (such as an air disaster), there is no need to wait 7 years; furthermore, disappearance does not automatically freeze premium obligations, and stopping payments causes the policy to lapse.

b. ✗ Incorrect. The 2-year period refers to incontestability under s.52 or the limitation period after a declaration of presumption of death under s.76(2), not a disappearance waiting period; additionally, a presumption of death order resolves only whether death has occurred and does not automatically reinstate a policy that lapsed for non-payment.

c. ✓ Correct. Under the general exam rule, a petition for a presumption of death can be made after 7 years of absence, but where sufficient circumstantial evidence exists, such as an air crash, the court can determine death without waiting; meanwhile, premiums must continue to be paid to keep the policy in force (otherwise the claimant must prove the presumed date of death occurred prior to policy lapse). (Note: While the exam rule cites 7 years of absence, BC Presumption of Death Act s.3 applies three statutory criteria without a fixed time threshold; candidates should answer using the exam general rule).

d. ✗ Incorrect. The 6-year period is the maximum limitation period measured from the date of death under s.76, not a waiting period for presumption of death; moreover, filing a missing-person police report does not trigger a premium waiver.

205′ answer a

a. ✓ Correct. Under both the exam standard and BC statutory law, when sufficient circumstantial evidence exists, such as flight boarding records in an air disaster, the court can grant a declaration of presumption of death without waiting 7 years; under s.76(2), once a declaration of presumption of death is made, a separate limitation period to commence an action runs for 2 years from the date of the declaration. (Note: The exam rule uses 7 years as a general benchmark, whereas BC Presumption of Death Act s.3 sets no fixed time threshold).

b. ✗ Incorrect. An air disaster provides sufficient circumstantial evidence of death, which exam materials specifically cite as a classic exception to the 7-year waiting rule; furthermore, s.76(2) establishes that the limitation period following a declaration of presumption of death is 2 years rather than 6 years.

c. ✗ Incorrect. A court order granted under the Presumption of Death Act constitutes statutory proof of death (and the court may order payment of insurance money under Insurance Act s.79); the insurer cannot insist on waiting 7 years.

d. ✗ Incorrect. The 15-day timeframe is the deadline for an insurer to provide claim forms in individual A&S, whereas the life insurance payment deadline is 30 days under s.73; additionally, there is an explicit 2-year limitation period following a declaration of presumption of death under s.76(2).

206 answer a

a. ✓ Correct. When aware of adverse claimants, an agent must disclose the competing claims to the insurer and assist with claim submission without taking sides or predicting outcomes; when an insurer admits liability to pay but faces adverse claimants, it satisfies the requirements of s.82 to apply for payment into court, thereby obtaining a statutory discharge.

b. ✗ Incorrect. Falls into the mistaking payment into court for claim denial trap. The precondition for payment into court under s.82 is that the insurer has admitted liability to pay (disputing entitlement rather than liability), and it is never a mechanism to deny a claim or cancel a policy.

c. ✗ Incorrect. BC law permits designating or altering a beneficiary by will under s.61, and a later designation can supersede an earlier one; an agent must neither provide incorrect legal conclusions nor advise a claimant to drop their claim.

d. ✗ Incorrect. Confuses the timing boundary of the record discharge rule under s.77. Section 77 only protects payments made in accordance with existing records before the insurer receives documentation or an order affecting entitlement at its head or principal office in Canada; because conflicting claims were received before payment, the insurer cannot simply pay the former spouse.

206′ answer c

a. ✗ Incorrect. Insurers seek to avoid paying the wrong party and having to pay again; s.77 specifically establishes record discharge protection, placing the risk of failing to deliver change documents onto the customer side and relieving the insurer from paying twice.

b. ✗ Incorrect. A declaration as to sufficiency of proof under s.78 resolves disputes prior to payment regarding whether submitted evidence is adequate, rather than governing post-payment record discharge.

c. ✓ Correct. Under BC Insurance Act s.77 (record discharge), until the insurer receives at its head or principal office in Canada notice or documentation affecting entitlement, payment made in accordance with its existing records discharges the insurer to the extent of the amount paid ($250,000).

d. ✗ Incorrect. An insurer has no obligation to search a deceased person's home, and the provincial regulator (Insurance Council of BC) regulates agent licensing and conduct rather than penalizing insurers for paying according to records in compliance with the law.

207 answer d

a. ✗ Incorrect. Both the exam standard and BC statutory law reject the outdated notion that the younger survived the older; when the sequence of death cannot be established, statutory presumptions apply (deeming the beneficiary to have died first).

b. ✗ Incorrect. Falls into the applying the five-day survival rule to simultaneous death trap. WESA s.11 explicitly provides that the five-day survival rule does not apply to insurance money governed by Insurance Act s.83, and proceeds are not split equally between the two estates.

c. ✗ Incorrect. Completely reverses the statutory direction of the presumption: in simultaneous death or uncertain order of death, the statutory presumption is that the beneficiary died before the life insured, not that the life insured died first.

d. ✓ Correct. In simultaneous death or where the sequence is uncertain and the contract does not provide otherwise, s.83 deems the beneficiary to have died before the life insured; because no other surviving primary or contingent beneficiary exists, s.63 directs payment to the policyholder's or insured's estate representative; furthermore, WESA s.11 explicitly excludes insurance money from the five-day survival rule.

207′ answer b

a. ✗ Incorrect. A predeceased beneficiary is not alive at the time of the insured event; unless the contract or declaration provides otherwise, that deceased beneficiary's share does not pass into their estate.

b. ✓ Correct. Under both the general exam rule and BC Insurance Act s.63, unless the contract or a declaration provides otherwise, the share of a predeceased beneficiary passes to the surviving beneficiaries in equal shares (only reverting to the policyholder or their estate representative if no designated beneficiary survives).

c. ✗ Incorrect. As long as other designated beneficiaries survive, the share of the predeceased beneficiary is divided equally among the surviving beneficiaries under s.63, rather than reverting that one-third share to the policyholder's estate.

d. ✗ Incorrect. The prior death of one beneficiary is a routine occurrence with clear statutory distribution rules under s.63; it does not invalidate the entire designation, nor does it constitute an adverse claim requiring payment into court under s.82.

208 answer b

a. ✗ Incorrect. Confuses the sequence of the three statutory deadlines: 15 days is the insurer's deadline to provide claim forms after receiving notice, 30 days is the deadline for written notice, and 90 days (not 60 days) is the deadline for submitting proof.

b. ✓ Correct. Statutory conditions for individual A&S under s.101 require written notice of claim within 30 days, insurer provision of forms within 15 days, and proof of claim within 90 days; for payment deadlines, the general exam rule states 60 days for individual A&S, whereas BC statutory conditions provide 60 days for non-loss-of-time benefits, and 30 days after receiving proof for the initial loss-of-time payment, payable at least once every 60 days thereafter. (Note: Answer 60 days when asked about the general exam rule, but 30 days for initial payment when specified for BC loss-of-time benefits).

c. ✗ Incorrect. Falls into the assuming a blanket 60-day A&S payment deadline and confusing group insurance traps. The insurer has 15 days, not 30 days, to provide claim forms; group A&S payment timing is governed by the group contract rather than statutory conditions, and BC individual A&S requires the initial loss-of-time payment within 30 days.

d. ✗ Incorrect. Erroneously applies the life insurance rule of having no independent statutory notice and proof deadlines to individual A&S; furthermore, disability claims involve ongoing payments and ongoing assessment, during which the insurer is entitled to request updated Attending Physician's Statements (APS) and medical examinations.

208′ answer a

a. ✓ Correct. Disability (loss of time) claims are not settled in a single lump sum but involve ongoing payments and ongoing reviews, giving the insurer the right during the benefit period to require medical examinations and updated Attending Physician's Statements (APS); payment timing for group A&S is governed by the group contract, as statutory conditions apply to individual contracts.

b. ✗ Incorrect. The 2–year incontestability period under s.52 governs whether innocent non–disclosure at application can void the policy, and it does not prohibit an insurer from verifying ongoing disability and requesting updated APS forms during the benefit period.

c. ✗ Incorrect. Group A&S payment timing is determined by the group policy terms rather than codified by statute; 15 days is the deadline in individual A&S for an insurer to furnish claim forms upon receiving notice.

d. ✗ Incorrect. Under BC Insurance Act s.104(3), the limitation period for non–death A&S claims is 2 years from the date the claimant knew or ought to have known of the claim (the earlier of 2 years from proof or 6 years from death applies only to death claims under s.104(1)).

209 answer a

a. ✓ Correct. The rule against payments contrary to public order is exceptionally strict: when a beneficiary unlawfully causes the death of the life insured, triggering public policy forfeiture, they are barred from receiving proceeds regardless of whether they had a profit motive or knew they were named beneficiary; however, this forfeiture bars only that culpable beneficiary, while the policy contract remains valid and proceeds are distributed to the remaining innocent beneficiary or the estate.

b. ✗ Incorrect. Falls into the assuming an unknowing beneficiary avoids public order forfeiture trap. On the exam, any option treating lack of knowledge or absence of insurance fraud motive as a justification for payment is incorrect, because public policy and common law do not permit anyone to benefit from their own criminal act.

c. ✗ Incorrect. Confuses beneficiary forfeiture with contract invalidity. Forfeiture by a beneficiary who causes the death affects only that culpable individual, whereas the policy contract itself remains valid and innocent co–beneficiaries or the estate are not disqualified.

d. ✗ Incorrect. The 2–year incontestability period under s.52 applies solely to innocent misrepresentation or non–disclosure at application and never protects against criminal acts causing death contrary to public order.

209′ answer d

a. ✗ Incorrect. BC Insurance Act s.56 explicitly confirms that suicide exclusion clauses are lawful and enforceable; furthermore, the 2–year incontestability provision under s.52 expressly states that fraud is never protected.

b. ✗ Incorrect. Policies typically stipulate that suicide within 2 years of issue or reinstatement is excluded (confirmed as valid under s.56); dying by suicide within 2 years of reinstatement falls squarely within the reinstated 2–year exclusion window.

c. ✗ Incorrect. Completely reverses the protections of the incontestability period under s.52: after 2 years in force, innocent non–disclosure no longer renders the contract voidable, whereas deliberate fraud remains an actionable ground for rescission or claim denial at any time.

d. ✓ Correct. Section 56 confirms that policy clauses excluding suicide within 2 years of issue or reinstatement are lawful and enforceable (suicide within 2 years of reinstatement is therefore excluded); the 2–year incontestability provision under s.52 protects innocent misrepresentation or non–disclosure once in force for 2 years, but deliberate fraud is never protected and may be contested at any time.

210 answer c

a. ✗ Incorrect. Assuming insurance proceeds for a minor beneficiary can be paid directly to a parent is a common misconception; unless the parent has been formally appointed as a trustee for the insurance funds or a property guardian, the insurer cannot release the money directly to the parent.

b. ✗ Incorrect. Under BC Insurance Act s.88(4), a beneficiary who has reached age 18 has the same capacity to receive insurance money and discharge the insurer as an adult; proceeds are paid directly to her and are never forfeited to the insurer.

c. ✓ Correct. This tests the dual standard between the exam general rule and BC statutory law: exam materials note that some provinces may require payment into court to protect a minor's funds, whereas BC follows the s.88 trust mechanism—paying a designated trustee, or paying the Public Guardian and Trustee if no trustee exists; furthermore, s.88(4) explicitly provides that a beneficiary aged 18 or older is treated as an adult with full legal capacity to receive proceeds and discharge the insurer directly. (Note: Distinguish between the exam standard of payment into court in some provinces versus BC s.88 paying the trustee or Public Guardian and Trustee, and treating 18–year–olds as adults).

d. ✗ Incorrect. Minors can validly be named as policy beneficiaries; they simply lack legal capacity to give a binding discharge before reaching age 18, requiring payment to be managed through a designated trustee or the Public Guardian and Trustee.

210′ answer b

a. ✗ Incorrect. Proceeds under a regular life insurance policy are paid to the designated beneficiary (unless subject to specific court orders such as child or spousal support); there is no statutory rule allowing a spouse to automatically override a named beneficiary on regular life insurance.

b. ✓ Correct. The death benefit under the regular life insurance policy goes to the named beneficiary (the adult brother); in contrast, pension–derived locked–in funds follow a statutory priority order where a qualifying spouse ranks ahead of any designated beneficiary, passing to the named beneficiary only if there is no qualifying spouse, and reverting to the estate only if neither exists.

c. ✗ Incorrect. Pension–derived funds are governed by pension standards legislation giving a qualifying spouse statutory priority; payout methods and unlocking exceptions must comply with pension law and cannot be overridden by an ordinary beneficiary designation.

d. ✗ Incorrect. The Public Guardian and Trustee under s.88 is involved only when a beneficiary is a minor under age 18 with no designated trustee, which is irrelevant to adult beneficiaries or spousal priority.

Chapter 31 answers and reasons

211 answer a

a. ✓ Correct. "The federal government regulates money, while provinces regulate people" is the core division of this chapter: The Office of the Superintendent of Financial Institutions (OSFI) is responsible under the Insurance Companies Act for determining the financial soundness of federally registered life insurers, while licensing, practice supervision, and disciplinary actions for misconduct of agents in BC fall under the Insurance Council of British Columbia.

b. ✗ Incorrect (Trap: Misallocating federal and provincial jurisdiction). The exam standard specifically emphasizes that OSFI does not licence or regulate insurance agents; an agent using fabricated illustrations to induce replacements falls under provincial market conduct and disciplinary jurisdiction.

c. ✗ Incorrect (Trap: Swapping the two BC bodies and confusing the role of Assuris). In British Columbia, the power of day–to–day licensing and discipline over individual agents rests with the Insurance Council of BC, not BCFSA; Assuris is an insolvency compensation fund, whereas routine capital adequacy and solvency supervision fall under OSFI.

d. ✗ Incorrect (Trap: Overstepping authority between dispute mediation and interprovincial coordination bodies). The OmbudService for Life and Health Insurance (OLHI) is an independent dispute resolution body without authority to revoke licences; the Canadian Council of Insurance Regulators (CCIR) is an inter–jurisdictional coordinating association that does not conduct federal solvency audits.

211′ answer c

a. ✗ Incorrect (Trap: Misallocating federal and provincial jurisdiction). The Office of the Superintendent of Financial Institutions (OSFI) oversees only the financial soundness of federally registered insurers and has no authority to intervene in provincial agent licensing or disciplinary hearings.

b. ✗ Incorrect (Trap: Complete misallocation of provincial bodies' roles). The Insurance Council of BC does not oversee federal insurers' capital reserves, and the authority to revoke an individual agent's licence belongs to the Insurance Council of BC, not BCFSA.

c. ✓ Correct. Solvency and capital adequacy are nationwide matters governed by federal OSFI under the Insurance Companies Act; an agent forging signatures is a local individual practice breach investigated and disciplined by the provincial licensing and disciplinary body, the Insurance Council of British Columbia.

d. ✗ Incorrect (Trap: Coordinating body and complaint service exceeding authority). CISRO is an intermediary standards coordinating organization that does not oversee insurer capital; OLHI is an independent dispute resolution service without authority to fine agents.

212 answer b

a. ✗ Incorrect (Trap: Confusing the BC Insurance Act with the Financial Institutions Act). The exam standard explicitly states that there is no specific Chapter regarding agents in the Insurance Act of BC; the Insurance Act governs insurance contracts themselves (such as beneficiary designations and incontestability).

b. ✓ Correct. In British Columbia, substantive provisions governing insurance agents are set out in the Financial Institutions Act (FIA), with the exam standard explicitly noting specific sections: s. 79 (premium rebating), s. 94 (tied selling), ss. 168—180 (licensing of insurance agents), and ss. 252—253.1 (offences and penalties).

c. ✗ Incorrect (Trap: Confusing the federal corporate statute with provincial agent law). The federal Insurance Companies Act governs the incorporation and financial soundness of federally registered insurers, not provincial agent commission rebating or licensing.

d. ✗ Incorrect (Trap: Confusing privacy law with financial institutions legislation). BC's Personal Information Protection Act (PIPA) governs the collection, use, and disclosure of personal information in the private sector, not premium rebating, tied selling, or agent licensing.

212′ answer a

a. ✓ Correct. In British Columbia, the Insurance Act governs contract–level rules and has no dedicated chapter on agents; substantive provisions governing agent licensing (ss. 168—180), prohibiting rebating (s. 79), prohibiting tied selling (s. 94), and imposing administrative penalties (s. 253.1) are all codified in the Financial Institutions Act (FIA).
b. ✗ Incorrect (Trap: Completely reversing the BC Insurance Act and Financial Institutions Act). Beneficiary designations and incontestability belong to contract law under the Insurance Act; agent licensing and rebating prohibitions belong to the Financial Institutions Act.
c. ✗ Incorrect (Trap: Assuming a single Insurance Act covers both contracts and agents). The exam standard specifically reminds candidates that the BC Insurance Act has no dedicated chapter on agents; agent rules must be found in the Financial Institutions Act alongside Council Rules and the Code of Conduct.
d. ✗ Incorrect (Trap: Confusing anti–money laundering legislation with provincial agent regulation). The Proceeds of Crime (Money Laundering) and Terrorist Financing Act (PCMLTFA) is federal anti–money laundering legislation that does not govern provincial agent licensing or premium rebating.

213 answer b

a. ✗ Incorrect (Trap: Inverting Assuris protection limits and reversing procedural order). The liquidator first attempts to transfer policies to another solvent insurer, rather than immediately canceling policies for cash surrender; furthermore, the Assuris rule is whichever is higher between the fixed dollar threshold and percentage, not whichever is lower.
b. ✓ Correct. When an insurer becomes insolvent, the liquidator first attempts to transfer policies to another insurer; if benefits must be cut, under the exam standard (2022 TABLE 4.1), the death benefit is protected up to "whichever is higher between $200,000 or 85% of promised benefits", which is max($200,000, 85% * $500,000) = $425,000. (Note: The 2022 exam table sets $200,000 or 85%, yielding $425,000, whereas the 2026 current Assuris standard has been increased to $1,000,000 or 90%, under which this $500,000 policy would receive full $500,000 protection.)
c. ✗ Incorrect (Trap: Assuming an application and fee are required, and calculating the gap amount instead). Federally regulated insurers and most provincially regulated insurers must belong to Assuris, and policyholders receive protection automatically without application or additional fees; $75,000 represents the 15% uncovered gap under the exam standard, not the protected benefit amount.
d. ✗ Incorrect (Trap: Calculating 'whichever is higher' as the sum of both). Assuris rules protect whichever is higher between the fixed dollar floor ($200,000) and the percentage ($425,000), capped at the original contractual benefit; it never adds the two together.

213′ answer d

a. ✗ Incorrect (Trap: Misallocating threshold amounts and stating 'whichever is lower' instead of 'whichever is higher'). In the exam standard (2022 TABLE 4.1), $200,000 is the death benefit floor, $100,000 is the accumulated value limit, and the rule is whichever is higher, not whichever is lower.
b. ✗ Incorrect (Trap: Confusing the 2022 exam table with 2026 current values and inventing an application requirement). $5,000/month, $250,000, and $100,000 are the 2026 current floor figures after Assuris increased limits in 2023 (paired with a 90% ratio), not the figures from exam TABLE 4.1; furthermore, Assuris protection applies automatically without any application.
c. ✗ Incorrect (Trap: Assuming clients must apply or pay extra to receive Assuris coverage). While the three figures match exam TABLE 4.1, all federally regulated insurers and most provincially regulated insurers must belong to Assuris, so clients are covered automatically without paying extra premiums.
d. ✓ Correct. Under the exam standard (2022 TABLE 4.1), Assuris coverage for monthly income, health expense, and cash value is $2,000/month, $60,000, and $60,000 respectively (or 85% of promised benefits, whichever is higher), and protection applies automatically without application. (Note: 2026 current standards have been raised to $5,000/month for monthly income, $250,000 for health expense, and $100,000 for cash value, or 90% of promised benefits, whichever is higher.)

214 answer c

a. ✗ Incorrect (Trap: Overlooking the 24-hour aggregation rule). The $10,000 threshold for a Large Cash Transaction Report (LCTR) applies not only to single transactions, but also under the 24 consecutive hour aggregation rule (24-hour rule): splitting an $18,000 transaction into two $9,000 deposits within the same 24-hour window totals $10,000 or more, thereby triggering the reporting requirement.

b. ✗ Incorrect (Trap: Confusing FINTRAC 24-hour aggregation window with reporting deadlines). The 24 consecutive hours is the window for determining whether multiple transactions aggregate to reach the $10,000 threshold, not the deadline for filing the report; the submission deadline for an LCTR is within 15 calendar days of receiving the cash.

c. ✓ Correct. Two cash payments of $9,000 (totaling $18,000) occurred within a 24 consecutive hour window for the same client and contract, triggering the $10,000 Large Cash Transaction Report (LCTR) threshold; the statutory filing deadline for an LCTR is within 15 calendar days from the date the cash is received.

d. ✗ Incorrect (Trap: Confusing STR with LCTR and the 5-business-day LVCTR deadline). The stem explicitly states there are no reasonable grounds to suspect money laundering, so the objective dollar threshold triggers an LCTR rather than a Suspicious Transaction Report (STR); furthermore, the deadline for an STR is "as soon as practicable", whereas 5 business days applies to Large Virtual Currency Transaction Reports (LVCTR).

214′ answer b

a. ✗ Incorrect (Trap: Applying the $10,000 LCTR cash threshold to an STR). A Suspicious Transaction Report (STR) has no minimum dollar threshold and is not limited to cash transactions; a report is required as soon as reasonable grounds to suspect are established.

b. ✓ Correct. When an agent acting as a reporting entity completes measures establishing reasonable grounds to suspect, a Suspicious Transaction Report (STR) is triggered regardless of the transaction amount; its submission deadline has no fixed number of days, but must be made "as soon as practicable".

c. ✗ Incorrect (Trap: Applying the 15-calendar-day LCTR deadline to an STR). The 15 calendar days deadline applies to Large Cash Transaction Reports (LCTR); an STR requires priority handling and must be submitted as soon as practicable.

d. ✗ Incorrect (Trap: Confusing report types, recipient agencies, and deadlines). Anti-money laundering reports are submitted to federal FINTRAC, not the Insurance Council of BC; furthermore, Electronic Funds Transfer Reports (EFTR) apply only to international wire transfers of $10,000 or more by defined financial entities (with a 5-business-day deadline).

215 answer a

a. ✓ Correct. "Go to the ombudservice for disputes, and go to the regulator for misconduct": Having exhausted the insurer's internal complaints process and received a final position letter, the client satisfies the prerequisite to request an independent review by the OmbudService for Life and Health Insurance (OLHI); meanwhile, an agent failing to disclose a conflict of interest breaches practice rules, falling under the disciplinary chain investigated by the Insurance Council of British Columbia.

b. ✗ Incorrect (Trap: Overstepping authority between dispute mediation and discipline). OLHI is an independent complaints resolution body that does not issue licences, suspend licences, or impose fines; disciplinary power to suspend or revoke an agent's licence belongs exclusively to provincial regulators (in BC, the Insurance Council of BC).

c. ✗ Incorrect (Trap: Assuming the Insurance Council adjudicates contract dispute compensation for clients). The Insurance Council of BC regulates agent licensing and discipline; it does not adjudicate policy performance disputes between clients and insurers.

d. ✗ Incorrect (Trap: Confusing the mandates of FCAC and CISRO). FCAC oversees consumer compliance for federally regulated entities such as banks and does not arbitrate life insurance contract disputes; CISRO hosts an interprovincial disciplinary database and coordinates standards, but cannot directly revoke an agent's licence.

215′ answer c

a. ✗ Incorrect (Trap: Inventing an OSFI referral prerequisite). A client does not need a referral from OSFI to access OLHI; the sole prerequisite is exhausting the insurer's internal complaints handling process.

b. ✗ Incorrect (Trap: Confusing a life and health dispute service with a property and casualty insolvency fund). OLHI specifically handles life and health insurance complaints; the Property and Casualty Insurance Compensation Corporation (PACICC) is the insolvency compensation fund for general insurance.

c. ✓ Correct. The first step in the complaints chain is always the insurer's internal complaints process, and the client must obtain the insurer's final position letter before approaching OLHI; furthermore, OLHI is an independent dispute resolution body rather than a regulatory enforcement agency and has no power to fine insurers or agents.

d. ✗ Incorrect (Trap: Mistaking OLHI service target timelines for a statutory waiting period and granting it fine-levying power). OLHI has no statutory authority to levy fines, and 120 days (or 45 days at the investigation stage) is an internal service delivery target, not a legislated waiting period.

216 answer d

a. ✗ Incorrect (Trap: Overlooking BC's substantially similar privacy statute, PIPA). British Columbia, Alberta, and Quebec each possess provincial private-sector privacy legislation deemed substantially similar to the federal Personal Information Protection and Electronic Documents Act (PIPEDA); in BC, the governing statute is PIPA (SBC 2003, c. 63).

b. ✗ Incorrect (Trap: Confusing public-sector FOIPPA with private-sector PIPA). FOIPPA regulates public-sector bodies (government entities), whereas private-sector life insurance agencies in BC are governed by PIPA, with oversight enforced by OIPC BC rather than the Insurance Council of BC.

c. ✗ Incorrect (Trap: Crediting rumors of privacy law repeal). The federal privacy reform bill (Bill C-36) remains at second reading in Parliament and has not received Royal Assent; both PIPEDA and BC's PIPA remain fully in force.

d. ✓ Correct. British Columbia has its own private-sector privacy statute, the Personal Information Protection Act (PIPA), deemed substantially similar to federal legislation, so commercial activities within BC are generally governed by PIPA (supervised by OIPC BC); however, when commercial personal information crosses provincial or national borders, federal PIPEDA may apply.

216′ answer a

a. ✓ Correct. Under federal PIPEDA provisions, in provinces with private-sector privacy legislation deemed substantially similar (BC, Alberta, Quebec), commercial activities within the province are generally governed by the provincial statute; in BC, that statute is PIPA, independently enforced by OIPC BC.

b. ✗ Incorrect (Trap: Absolutely excluding PIPEDA applicability). In provinces without substantially similar private-sector privacy legislation, or where commercial personal information moves across provincial or national boundaries, PIPEDA continues to apply to insurance intermediaries and transactions.

c. ✗ Incorrect (Trap: Confusing a provincial privacy statute with a federal anti-money laundering agency). PIPA is a BC provincial statute (SBC 2003, c. 63) enforced by the Office of the Information and Privacy Commissioner for BC (OIPC BC), with no connection to federal FINTRAC.

d. ✗ Incorrect (Trap: Conflating unrelated historical events). BCFSA replacing FICOM in 2019 was a restructuring of BC's provincial financial regulator; federal PIPEDA was never repealed and remains valid federal law.

217 answer c

a. ✗ Incorrect (Trap: Misremembering E&O and CE figures and confusing the role of Assuris). The minimum E&O limit in BC is not $500,000, and annual CE is not 24 credits (24 is the standard supervision period in months for new agents); furthermore, Assuris only protects policyholders when an insurer becomes insolvent, not when an agent lets coverage lapse or breaches rules.

b. ✗ Incorrect (Trap: Inverting per-claim and aggregate E&O limits and granting disciplinary power to OLHI). $2,000,000 is the aggregate minimum limit rather than the per-claim limit; CE requires 15 credits per licence period rather than 5 credits (5 is the number of licence periods for retaining records and the number of business days to notify Council of an E&O lapse); and OLHI has no authority to fine agents.

c. ✓ Correct. Under current Insurance Council of BC rules, an agent must maintain errors and omissions (E&O) insurance of at least $1,000,000 per claim and $2,000,000 aggregate, and must notify Council within 5 business days of any policy lapse; complete 15 continuing education (CE) credits per licence period (June 1 to May 31) and retain records for 5 licence periods; and failing to report an E&O lapse or falsely declaring CE completion is subject to disciplinary action by the Insurance Council.

d. ✗ Incorrect (Trap: Confusing federal OSFI jurisdiction with CE periods). $1,000,000 is the per-claim limit rather than the aggregate limit, 15 CE credits is an annual requirement per licence period (every two years is the review cycle for FINTRAC compliance program effectiveness), and OSFI does not revoke agent licences.

217′ answer b

a. ✗ Incorrect (Trap: Assuming E&O covers intentional fraud and shortening the CE retention period). Errors and omissions (E&O) insurance covers only negligence, errors, and omissions in practice, and never covers intentional acts or fraud; furthermore, CE records must be retained for 5 licence periods.

b. ✓ Correct. Run-off coverage continues to protect a retiring or departing agent against negligence claims arising from acts committed during past licensed years; in addition, under Insurance Council of BC rules, licensees must complete 15 CE credits per period and retain records for 5 licence periods.

c. ✗ Incorrect (Trap: Confusing Assuris insolvency protection with agent professional liability insurance). Assuris protects policyholders only when an insurer becomes insolvent and benefits are reduced; it never covers an individual agent's professional liability for negligence.

d. ✗ Incorrect (Trap: Confusing the roles of CISRO and the Insurance Council). CISRO is an interprovincial coordinating body that does not market or manage E&O coverage, nor does it audit BC agents' CE records (CE is administered by the Insurance Council of BC under Rule 7(5) and Rule 4(4)).

Chapter 32 answers and reasons

218 answer a

a. ✓ Correct. The FINTRAC $10,000 identity verification (know your client / KYC) threshold is calculated on a cumulative basis across all expected payments over the entire duration of the policy or annuity, rather than per single installment. An annual premium of $2,000 over 15 years totals well over $10,000, so Tariq must verify Mei's identity within 30 days of creating the information record using one of the five statutory methods, such as valid government–issued photo ID.

b. ✗ Incorrect (Trap: Treating the $10,000 verification threshold as a single–payment amount). As long as total expected payments over the contract duration may reach $10,000, identity verification must be completed within 30 days of creating the information record, and cannot be deferred until the fifth anniversary when cumulative payments actually reach $10,000.

c. ✗ Incorrect (Trap: Using financial instruments to substitute for statutory identification). None of the five statutory verification methods permits using a credit card or personal cheque; inspecting commercial financial instruments in person cannot replace statutory identification documents or qualified dual–source records.

d. ✗ Incorrect (Trap: Confusing triggering milestones). A non–exempt policy expected to accumulate $10,000 requires verifying the applicant's identity within 30 days of creating the information record; the milestone for verifying a beneficiary whose cumulative payout is expected to reach $10,000 is prior to the first transfer of funds or virtual currency, not the policy application signing date.

218′ answer c

a. ✗ Incorrect (Trap: Relying on an ineligible level of government ID). Government–issued photo ID must be issued by the federal, provincial, or territorial government of Canada (or a foreign equivalent); cards issued by a municipal government cannot be used for FINTRAC identity verification.

b. ✗ Incorrect (Trap: Confusing the scope of exemptions). Exemptions from identity verification apply to registered annuities (such as RRSP, RRIF, or TFSA contracts), exempt life insurance policies, and accident and sickness policies without cash value; non–registered annuities are not exempt.

c. ✓ Correct. The non–registered annuity's total expected deposits over its duration exceed $10,000 ($2,000 quarterly over 3 years), triggering the requirement to verify client identity (KYC) within 30 days of creating the information record; because a municipal pass is invalid, Victor must use an approved statutory method, such as federal or provincial photo ID, an immediate query of a credit file existing for at least 3 years, or the dual–process method.

d. ✗ Incorrect (Trap: Non–compliant verification method). When using the single–source credit file method, the agent must personally conduct an immediate query of a Canadian credit bureau at the time of verification; a paper photocopy printed by the client at home or an outdated previously obtained report is unacceptable.

219 answer b

a. ✗ Incorrect (Trap: Improperly replacing statutory forms). Specific replacement disclosures must be executed using the prescribed Life Insurance Replacement Declaration (LIRD); an agent cannot substitute a general explanation letter, let alone have the client sign blank forms in advance.

b. ✓ Correct. Disclosure about replacement is a mandatory statutory obligation. The agent must complete the LIRD and a written comparison covering policy differences, replacement rationale, inherent risks, cash values, and adverse tax consequences, explain them in person point by point, and provide copies to both the client and the insurer; client time pressure never justifies skipping this process.

c. ✗ Incorrect (Trap: Treating coverage upgrades as non–replacements). Even when an upgrade appears to increase coverage or enhance benefits, substituting an existing policy with a new contract (or utilizing cash values from an old policy to fund a new one) constitutes a replacement, triggering the mandatory LIRD process.

d. ✗ Incorrect (Trap: Omitting discussions to avoid losing a sale). Using a client's rush to catch a flight as an excuse to withhold inherent risks or adverse tax consequences violates statutory replacement disclosure obligations.

219′ answer d

a. ✗ Incorrect (Trap: Narrowing statutory scope). Replacement rules apply whenever an existing life insurance contract is replaced, whether internally within the same insurer or externally to another company; both require the prescribed LIRD and written comparison.

b. ✗ Incorrect (Trap: Using client trust to omit written disclosure). Long-standing client trust or verbal assent never waives the statutory obligation to prepare a written comparison, conduct an in-person review, and provide copies to the client.

c. ✗ Incorrect (Trap: Applying withdrawn Guideline G19). CLHIA Guideline G19 never took full effect and was withdrawn entirely; furthermore, routine compensation disclosure cannot substitute for statutory replacement LIRD obligations.

d. ✓ Correct. Whether replacing a policy internally within the same insurer or externally with another company, any transaction constituting a replacement (including using existing cash value to buy a new policy) requires completing the Life Insurance Replacement Declaration (LIRD) and written comparison, reviewing them with the client, and retaining copies.

220 answer c

a. ✗ Incorrect (Trap: Dual compliance misconception). Skipping fact-finding and failing to retain written records breaches needs-based sales principles even if the product happens to fit; moreover, discovering a material change in insurability prior to policy delivery strictly prohibits handing over the contract under original terms.

b. ✗ Incorrect (Trap: Confusing procedures). A client requesting a specific product does not relieve the agent of the obligation to conduct a needs analysis and create written records; additionally, a material change in health requires withholding delivery rather than simply making an entry in a complaint log after delivery.

c. ✓ Correct. Liam breached needs-based sales practices by skipping fact-finding and failing to document his recommendation in writing, regardless of whether the product fits; furthermore, when a material change in insurability occurs between application and delivery, the agent must not deliver the contract, but must withhold delivery and refer the file to the insurer for reassessment.

d. ✗ Incorrect (Trap: Treating E&O as an all-purpose shield). Errors and Omissions (E&O) insurance covers agent professional liability for negligence, errors, or omissions; it is not a mechanism to underwrite or assume a client's newly developed cardiac medical risk.

220′ answer a

a. ✓ Correct. The industry best-practice six-step sequence (initial disclosure, understanding expectations, fact-finding, needs assessment, providing recommendations, and explaining product information) does not permit bypassing intermediate steps; skipping fact-finding and assessment leaves the agent without auditable evidence that client needs were understood, constituting a breach of suitability rules.

b. ✗ Incorrect (Trap: Misunderstanding document purpose). A reason-why letter serves as evidence that the agent fulfilled analytical and explanatory duties, not as proof of insurer underwriting approval, and it cannot substitute for proper fact-finding.

c. ✗ Incorrect (Trap: Confusing module-specific terminology). The Ethics module requires the comprehensive process of gathering facts, assessing needs, explaining recommendations, and retaining written records, rather than relying on a specific document title to waive fact-finding.

d. ✗ Incorrect (Trap: Confusing KYC thresholds with suitability obligations). The $10,000 figure is the cumulative threshold for FINTRAC identity verification; needs analysis and suitability requirements apply to every insurance recommendation without any dollar threshold.

221 answer d

a. ✗ Incorrect (Trap: Dual misconception of E&O as an all-purpose shield and 30 days as a grace period). Thirty days is not an uninsured practice grace period, and E&O insurance strictly excludes intentional or criminal acts such as forgery.

b. ✗ Incorrect (Trap: Confusing two independent statutory obligations). Automatic licence suspension after 30 calendar days of lapsed coverage is one rule; notifying the Council within 5 business days of a lapse is a separate, independently enforceable obligation that cannot be postponed.

c. ✗ Incorrect (Trap: Conflating coverage concepts). Run-off insurance extends coverage for past negligent acts after retirement or licence surrender, but no E&O policy ever covers intentional acts, misappropriation, fraud, or forgery.

d. ✓ Correct. Under BC Council Rule 7(11) and disciplinary precedents, minimum E&O limits are $1,000,000 per claim and $2,000,000 aggregate; 30 days is not an uninsured practice grace period (licences are automatically suspended after 30 calendar days), an agent must notify the Council within 5 business days of a lapse, and E&O covers only negligence, errors, and omissions while excluding intentional acts such as forgery.

221′ answer b

a. ✗ Incorrect (Trap: Fabricating regulatory indemnification). The Insurance Council of BC is a regulatory and disciplinary body, not an insurer that pays civil negligence damages on behalf of retired agents.

b. ✓ Correct. When departing or retiring from active practice, an agent should arrange run-off insurance to maintain E&O protection against future claims arising from errors, omissions, or negligence committed during past licensed practice.

c. ✗ Incorrect (Trap: Improper destruction of records). Recordkeeping rules require retaining client files, including recommendations and client decisions, which serve as essential first-hand evidence to prove compliance if disputes arise.

d. ✗ Incorrect (Trap: Confusing distinct rules). The 30-calendar-day window applies to active licensees whose lapsed E&O triggers automatic licence suspension; it provides no post-retirement liability coverage.

222 answer a

a. ✓ Correct. The national exam standard classifies premium rebating and inducements as unfair or deceptive practices, and even in BC where FIA s. 79 permits rebating strictly below 25% of the premium, inducing an unsuitable policy is strictly prohibited; furthermore, commission sharing is permitted only with another properly licensed agent and must be disclosed to the client.

b. ✗ Incorrect (Trap: Applying withdrawn Guideline G19 and confusing commission sharing with referrals). CLHIA Guideline G19 was withdrawn on May 31, 2019, and never took effect; national exam rules prohibit rebating (BC permits only compliant rebates strictly below 25% of the premium), and commissions can never be shared with unlicensed individuals.

c. ✗ Incorrect (Trap: Confusing unlicensed referrals with licensed commission sharing). An unlicensed individual can receive only a referral fee, provided they engage in no insurance activities such as discussing needs or products; conducting a needs analysis constitutes unauthorized, unlicensed practice.

d. ✗ Incorrect (Trap: Breaching regulatory guidance). Even in BC where rebating strictly below 25% is permitted under specific conditions, the Council's 2022 guidance expressly prohibits inducing unsuitable sales through rebates or promising rebates on future renewal premiums.

222′ answer c

a. ✗ Incorrect (Trap: Confusing licence classes). Holding a licence in another insurance class is treated as being unlicensed for life insurance; agents cannot split commissions directly without complying with the disclosure rules for unlicensed referrals.

b. ✗ Incorrect (Trap: Applying withdrawn Guideline G19). CLHIA Guideline G19 was withdrawn in its entirety on May 31, 2019, and has no bearing on referral fees to unlicensed individuals.

c. ✓ Correct. BC rules permit paying a referral fee to an individual who is not licensed for life insurance, provided they engaged in no insurance activities (such as discussing insurance needs or product features) and the compensation is disclosed in writing to the client before arranging the transaction.

d. ✗ Incorrect (Trap: Evading regulations through nominal contracts). Labeling an agreement a referral contract does not permit an unlicensed person to engage in licensed activities; conducting a needs analysis or completing a LIRD constitutes illegal unlicensed practice.

223 answer b

a. ✗ Incorrect (Trap: Confusing churning with twisting). Churning occurs within the same insurer, whereas inducing a client to move from Alpha to Beta across insurers constitutes twisting; furthermore, Kevin personally executed the transaction, so fronting is not involved.

b. ✓ Correct. Inducing a client to replace a policy across different insurers (from Alpha to Beta) through misleading representations or concealing true costs to earn new commissions constitutes twisting; publishing malicious disparaging statements about an insurer or competitor on social media constitutes defamation.

c. ✗ Incorrect (Trap: Conflating distinct offenses). Tied selling involves conditioning the purchase of one product on buying another; trafficking in insurance involves brokering life policies between policyholders and third-party investors, neither of which applies here.

d. ✗ Incorrect (Trap: Dual concept confusion). Inducing a switch across insurers is twisting rather than internal churning; publicly disparaging an insurer is defamation, whereas holding out improperly refers to misleading the public regarding one's credentials, titles, or qualifications.

223′ answer a

a. ✓ Correct. Inducing clients to execute unnecessary policy replacements within the same insurer (Insurer Gamma) for the improper purpose of generating new commissions is the textbook definition of churning.

b. ✗ Incorrect (Trap: Confusing churning with twisting). Twisting specifically denotes inducing a policy replacement across different insurers through misleading representations, whereas unnecessary replacements within the same company constitute churning.

c. ✗ Incorrect (Trap: Conflating distinct violations). Fronting occurs when a licensee submits business under their name without having had direct contact with the client; Valerie directly sold unnecessary same-insurer replacements to her own clients.

d. ✗ Incorrect (Trap: Conflating distinct violations). Tied selling refers to coercing a customer into purchasing one product or service as a condition of obtaining another, which is unrelated to repeatedly churning policies within the same insurer.

224 answer c

a. ✗ Incorrect (Trap: Assuming non–criminal violations only receive warnings). As demonstrated in Council disciplinary precedents such as the Wu decision, falsely declaring CE compliance when audited short of credits still results in formal disciplinary sanctions, including fines and mandatory courses.

b. ✗ Incorrect (Trap: Misunderstanding E&O functions). Errors and omissions insurance covers liability for civil negligence causing client financial loss; it never indemnifies an agent against regulatory fines or completes missing CE credits.

c. ✓ Correct. Matching the Insurance Council of BC disciplinary decision in the Lili Wu matter (COM–2025–00389): falsely declaring CE completion on a renewal application when audited short of credits violates Council Rules 7(5), 7(8), and Code of Conduct competence requirements, resulting in a $500 fine, mandatory compliance courses, making up the 2 missing credits, and refusal to process new licence applications until all orders are satisfied.

d. ✗ Incorrect (Trap: Disregarding statutory procedural fairness). Under Financial Institutions Act s. 237, the Council must provide written notice and an opportunity to be heard before imposing disciplinary penalties.

224′ answer a

a. ✓ Correct. Matching the Insurance Council of BC disciplinary order in the Sahar Rezaei matter (COM–2024–01063): failing to maintain E&O coverage and failing to notify the Council within 5 business days of the lapse resulted under FIA ss. 231 and 241.1 in a $500 fine, $950 in investigation costs, mandatory completion of the Council Rules Course and an E&O course, plus automatic suspension and licence restrictions if deadlines are missed.

b. ✗ Incorrect (Trap: Underestimating reporting obligations). The duty to notify the Council within 5 business days of an E&O lapse is an independent mandatory statutory requirement; breaching it leads to disciplinary fines and enforcement cost orders.

c. ✗ Incorrect (Trap: Confusing administrative infractions with criminal offenses). Forgery and misappropriation violate the Criminal Code, whereas failing to report an E&O lapse is an administrative regulatory infraction under Council Rules, and suspension or cancellation does not constitute a criminal conviction.

d. ✗ Incorrect (Trap: Outcome–based excuse). Maintaining continuous E&O coverage and reporting a lapse within 5 business days are mandatory statutory licensing conditions; the absence of client claims during the lapse period does not excuse the regulatory violation.