



Guidewire ClaimCenter-Business-Analysts Practice Questions

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Question 1

Question Type: MultipleChoice

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

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

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

Options:

- A- Financials > Transactions
- B- History
- C- Notes
- D- Loss Details > Status

Answer:

B

Explanation:

In Guidewire ClaimCenter, the History screen serves as the automated audit trail for the claim file. It is designed to capture and display a chronological list of significant events and user actions that have occurred throughout the claim's lifecycle.

Audit Trail Functionality: The History screen automatically records specific types of events, including:

Field Changes: When critical fields (like Reserve Amounts) are modified, the system logs the 'Old Value' and the 'New Value.'

Assignment Changes: Tracks when the claim was transferred from one user to another.

Rule Execution: Logs when specific business rules (like 'Exception Flagged') are triggered.

Data Points: For each entry, the History screen displays the User who performed the action, the Timestamp of the event, and a Description of the change.

Why other options are incorrect:

Financials > Transactions (A): While this screen shows the financial T-account entries (debits/credits) for the reserve increase, its primary purpose is accounting analysis. It is less efficient for a supervisor looking for a simple 'Who/When/What' audit trail compared to the History screen.

Notes (C): Notes are typically used for qualitative narratives and manual entry. While a system note can be generated for a reserve change, the History screen is the dedicated, non-editable system of record for tracking field changes.

Loss Details > Status (D): This screen shows the current state of the claim (e.g., Open, Closed, Litigation Status) but does not provide a historical log of previous values or the specific user actions that led to the current state.



Question 2

Question Type: MultipleChoice

Which two best practices should a Business Analyst (BA) follow to be prepared for a Requirements Workshop? (Select two.)

Options:

- A- Invite end users with knowledge of related process.
- B- Review notes from Inception Workshop.
- C- Review base product functionality of ClaimCenter for related process.
- D- Review acceptance criteria.
- E- Ask the Project Manager to set an agenda.

Answer:

B, C



Explanation:

Preparation is key to a successful Requirements Workshop (or Elaboration Workshop). The BA must enter the room with a clear understanding of the project scope and the tool's capabilities.

Review Notes from Inception (B): The Inception Phase defines the high-level scope, vision, and business objectives. Reviewing these notes ensures the BA understands the boundaries of the discussion (e.g., 'We are doing Auto Hail damage, but not Property Hail damage yet') and the strategic goals defined by the sponsors.

Review Base Product Functionality (C): To effectively lead the session and recommend solutions

(as seen in Question 22), the BA must be familiar with how ClaimCenter handles the specific topic (e.g., Check Wizards, Coverage Verification) out-of-the-box. This allows the BA to demo standard features during the workshop to drive 'Fit-to-Standard' discussions rather than starting from a blank sheet of paper.

Why not A, D, or E? Inviting users (A) and setting agendas (E) are logistical tasks often handled by the Project Manager or shared; they are not 'personal preparation' of knowledge. Acceptance Criteria (D) are typically written during or after the workshop, not reviewed beforehand (unless refining an existing story).

Question 3

Question Type: MultipleChoice

An Adjuster at Succeed Insurance is handling a homeowners claim with a dwelling exposure for damage to the insured's home. The Adjuster's Authority Limit Profile has the following limits:

Limit Type	Policy Type	Coverage Type	Cost Type	Amount
Claim total reserves				\$15,000
Payments exceed reserves				\$1,000
Payment amount			Claim Cost	\$5,000
Payment amount			Expense - A&O	\$500

The table below is a view of the property claims organization within Succeed Insurance. The Adjuster is a member of the group Property - Team

A.

Group	Parent Group	Supervisor
Succeed Insurance		Supervisor A
Western Regional Claims Center	Succeed Insurance	Supervisor B
Western Property Group	Western Regional Claims Center	Supervisor C
Property - Team A	Western Property Group	Supervisor D
Property - Team B	Western Property Group	Supervisor E

The Adjuster creates a payment in the amount of \$6,500 for repairs to the insured's home. How will it be processed assuming that the claim has sufficient reserves for the payment?

Options:

- A- The payment requires approval. An approval activity will be generated and routed to Supervisor C.
- B- The payment requires no approval. It will be processed and issued to the insured.
- C- The payment requires approval. An approval activity will be generated and routed to Supervisor A.

D- The payment requires approval. An approval activity will be generated and routed to Supervisor D.

Answer:

D

Explanation:

This scenario involves checking financial Authority Limits and determining the correct Approval Routing hierarchy in Guidewire ClaimCenter.

Check Authority Limits: First, compare the transaction amount against the user's specific limits.

The payment is for 'repairs to the insured's home,' which is classified as Claim Cost (Indemnity).

According to the provided Authority Limit Profile, the Adjuster has a 'Payment amount' limit of \$5,000 for Claim Cost.

The transaction amount is \$6,500.

Since $\$6,500 > \$5,000$, the limit is exceeded, meaning the payment requires approval (Ruling out Option B).

Determine Routing: When a financial transaction requires approval, ClaimCenter routes the approval activity to the supervisor of the group to which the user belongs.

The Adjuster is a member of Property - Team A.

According to the Organization chart provided, the Supervisor for 'Property - Team A' is Supervisor D.

Therefore, the system will generate an approval activity and assign it specifically to Supervisor D. Supervisor C is the manager of the parent group (Western Property Group), so the activity would only go to them if Supervisor D also lacked the authority to approve the \$6,500, requiring further escalation. However, the initial routing is always to the immediate supervisor.

Why other options are incorrect:

Option A: Supervisor C is the 'Grand-boss' (Supervisor of the parent group), not the immediate supervisor.

Option B: The amount (\$6,500) clearly exceeds the defined limit (\$5,000), so automatic processing is impossible.

Option C: Supervisor A is at the top of the hierarchy (Succeed Insurance), far removed from the initial approval step.

Question 4

Question Type: MultipleChoice

A Business Analyst (BA) has identified a new typecode essential for Succeed Insurance implementation. During adjudication, Adjusters need to be able to update the loss cause value to reflect the new typecode.

Which tabs in a Guidewire Story Card should be used to document the business requirement?

Options:

- A- Change Summary, UI Fields, Typelist, Action Items, and Business Acceptance
- B- Document Control, UI Mockup, UI Fields, Typelist, and Business Acceptance
- C- Change Summary, UI Mockup, UI Fields, Typelist, and Action Items
- D- Document Control, UI Mockup, Typelist, Action Items, and Business Acceptance

Answer:

B

Explanation:

To fully document a requirement that involves both a User Interface change (updating a value on a screen) and a Data Model change (adding a new typecode), the standard Guidewire Story Card tabs required are:

Document Control: Captures the metadata (Author, Version, Owner) to track the requirement's history.

UI Mockup: visually illustrates where on the screen the 'Loss Cause' field is located and how the dropdown should appear to the Adjuster.

UI Fields: Defines the specific behavior of the field (e.g., Is it mandatory? Is it editable during adjudication? What is the label?).

Typelist: This is critical for this specific scenario. It lists the actual Code, Name, and Description of the new typecode being added to the 'Loss Cause' typelist.

Business Acceptance: Defines the testable criteria (Acceptance Criteria) to verify that the adjuster can successfully select the new value and save the claim.

Why Option B is correct: It is the only option that includes both the visual requirements (Mockup/Fields) and the data requirement (Typelist) alongside the standard control and testing tabs (Document Control/Business Acceptance).

Question 5

Question Type: MultipleChoice

An Adjuster at Succeed Insurance creates a check with a partial payment of \$1,200 for medical expenses payable to a claimant who was injured in a collision. The check has completed the following processing steps:

- . The payment exceeded the Adjuster's authority limits, changing the status to Pending Approval.
- . The Adjuster's supervisor reviewed and approved the payment, changing the status to Awaiting Submission.
- . A batch process sent the check to the external check processing system, changing the status to Requested when ClaimCenter received an update from the external system.

The Adjuster received new information indicating that the check amount should be reduced to \$950.

Which action should the Adjuster take?

Options:

- A- Edit the check and change the amount, then submit it for processing.
- B- Ask the bank to hold the check and create a new check for the correct amount.
- C- Stop the check and create a new check for the correct amount.
- D- Void the check and create a new check for the correct amount.

Answer:

D

Explanation:

250 to 350 words From Exact Extract of Guidewire ClaimCenter Business Analyst documentation:

In the lifecycle of a check within Guidewire ClaimCenter, the Requested status indicates that the payment instruction has been successfully handed off to the downstream check writing or electronic funds transfer system. Once a check reaches this status, it is considered a committed financial transaction and is locked from further editing.

Why Option A is incorrect: You cannot edit a check that is in 'Requested' status. The 'Edit' button will likely be disabled or the fields locked because the data has already left the system.

Why Option C is incorrect: A 'Stop' payment is typically reserved for scenarios where a physical check has been lost, stolen, or destroyed after it was printed and mailed. While a Stop Payment does prevent the check from being cashed, it is a specific banking process often involving fees.

Why Option D is Correct: To correct an administrative error (such as the wrong amount) for a check that has been processed but not yet negotiated (cashed), the standard procedure is to Void the check. Voiding the check in ClaimCenter performs two critical functions:

It reverses the financial T-accounts (reserves and payments) associated with the transaction, ensuring the claim financials are accurate.

It updates the status to 'Voided,' effectively cancelling the payment in the system.

After voiding the incorrect check (\$1,200), the Adjuster must then create a new check for the correct amount (\$950) to pay the claimant.

Question 6

Question Type: MultipleChoice

Which two components are necessary to create the check(s) using the wizard? (Choose two.)

Options:

- A- Payment tied to a reserve line
- B- Payment tied to an activity
- C- Payee
- D- Date of the claim

Answer:

A, C

Explanation:

The Check Wizard in Guidewire ClaimCenter enforces strict financial integrity rules. To successfully create a check, the user must define the source of funds and the recipient.

Payment tied to a Reserve Line (Option A): Every payment must be allocated to a specific Reserve Line (combination of Exposure, Cost Type, and Cost Category). This ensures that the payment consumes the correct financial reserves and maps to the correct coverage on the policy. You cannot create a 'floating' payment; it must be tied to a reserve line.

Payee (Option C): A check is a legal instrument that must be payable to a specific entity.

Selecting a Payee (from the claim contacts) is a mandatory step in the wizard.

Why other options are incorrect:

B (Activity): While payments can be linked to activities (e.g., Service Requests), it is optional. Most indemnity payments are made directly without an underlying activity.

D (Date of claim): The Loss Date is a property of the claim, but it is not a component selected or created during the check wizard process. The relevant dates in the wizard are the 'Service Period' or 'Scheduled Send Date.'

Question 7

Question Type: MultipleChoice

Why are unique requirement numbers so important for business analysis?

Options:

- A- Requirement numbers are not absolutely necessary but they make it easier to trace changes that occur.
- B- Requirement numbers are specific to the document control portion of the Story Card and allow the analyst to trace who did what and when.
- C- Requirement numbers are useful for technical support and allow customers to track back on root causes for a support ticket.
- D- Requirement numbers organize requirements with a unique ID and provide a standardized order for insertion of new requirements.

Answer:

C

Explanation:

Traceability is the primary driver for assigning unique identification numbers to every business requirement.

Root Cause Analysis (Option C): Throughout the software development lifecycle (SDLC), a requirement flows from the Business Analyst (User Story) to the Developer (Code) and the Tester (Test Case). When a defect is found in production (a support ticket), the unique requirement number allows the team to trace the issue backward. They can determine if the defect was caused by a coding error (Requirement was right, code was wrong) or a requirements gap (Code met the requirement, but the requirement was wrong). This link 'back

to the root cause' is critical for quality assurance and continuous improvement.

Why other options are incorrect:

A: Unique IDs are considered absolutely necessary in formal agile methodologies (like the one used by Guidewire) for traceability matrices.

B: Document control tracks the file history, not the granular requirement history.

D: While IDs do organize data, their function in 'standardized order for insertion' is administrative and secondary to the strategic value of traceability described in Option C.

Question 8

Question Type: MultipleChoice

Satisfied with the outcome of a Requirements Workshop, a Business Analyst (BA) attributed the success to preparation. The assigned task had been to document the requirements for capturing details on vehicle incidents for Personal Auto.

Before the session, the BA reviewed ClaimCenter functionality by creating a new Personal Auto Claim involving physical damage to a vehicle.

During review, the BA saw that ClaimCenter did not have a graphical representation of a vehicle with clickable hot spots to identify the damage areas like they have in their current application.

Upon further research, the BA found that Guidewire does offer this functionality and even provides a Graphical Incident Capture Accelerator to ease implementation.

During the workshop, the BA was able to clearly present all options for capturing vehicle incident details. Instead of having to develop the Vehicle Incident Capture functionality from scratch, the team was able to make a quick decision to add this functionality and end the meeting 30 minutes early.

Which two outcomes demonstrate the importance of preparing for a Requirements Workshop by becoming familiar with the features and functionality of ClaimCenter? (Select two.)

Options:

A- The BA prevented the team from rebuilding something in a less effective way.

B- The BA was able to compare their legacy process to how ClaimCenter handles the same business process.

C- The BA was able to gain team acceptance of the base product process instead of the legacy system process.

D- The BA was able to make decisions in advance about where gaps existed and where changes were needed.

Answer:

A, B

Explanation:

This scenario highlights the value of Feature Knowledge and Gap Analysis during preparation.

Prevention of unnecessary work (Option A): Because the BA researched and found the 'Graphical Incident Capture Accelerator,' the team avoided the costly mistake of deciding to 'develop the... functionality from scratch.' This is a direct outcome of the BA's preparation preventing an inefficient custom build.

Comparison of Legacy vs. New (Option B): The text details that the BA 'reviewed ClaimCenter functionality' and explicitly noted the difference ('saw that ClaimCenter did not have... like they have in their current application'). This ability to articulate the gap between the As-Is (Legacy) and the To-Be (Base ClaimCenter) allowed the BA to present the Accelerator as the perfect bridge solution.

Why other options are incorrect:

Option C: The team did not accept the 'base product process' (which lacked the graphics); they accepted the Accelerator (an add-on) to match the legacy expectation of clickable hot spots.

Option D: The decision was not made 'in advance.' The text states the team made the 'quick decision' during the workshop. The preparation enabled the team's decision, but the BA did not make it unilaterally beforehand.

Question 9

Question Type: MultipleChoice

An auto claim is owned by Adjuster1. The Customer Service Representative (CSR) that created the claim owns one follow-up activity on the claim. An Injury Specialist owns an injury exposure on the claim. All these persons are members of Auto Team 1.

The Team Lead determines that Adjuster1 is overworked and reassigns the claim to Adjuster2, a member of Auto Team 2.

Which three people now have access to the claim? (Choose three.)

Options:

A- Special Investigations Unit

- B- Adjuster1
- C- CSR
- D- Injury Specialist
- E- Adjuster2
- F- The Claimant

Answer:

C, D, E

Explanation:

250 to 350 words From Exact Extract of Guidewire ClaimCenter Business Analyst documentation:

In Guidewire ClaimCenter, access to a claim file is determined by Access Control Lists (ACLs), which are dynamically updated based on user roles and ownership. A user is granted access to a claim if they own the claim itself, or if they own a sub-object within that claim, such as an Activity or an Exposure.

Adjuster2 (Option E): Upon reassignment, Adjuster2 becomes the new Claim Owner. The owner of the claim record always has full view and edit access to the claim.

CSR (Option C): The CSR retains ownership of a specific Activity (the follow-up task). In the ClaimCenter security model, owning an open activity on a claim grants the user 'view' access to the parent claim so they can perform the necessary work to complete their task. Reassigning the claim header does not automatically reassign the activities owned by other users.

Injury Specialist (Option D): This user owns an Exposure (a distinct financial sub-record for a specific coverage feature). Similar to activities, owning an exposure grants access to the parent claim. The reassignment of the main claim file from Adjuster1 to Adjuster2 does not strip the Injury Specialist of their ownership of the specific injury exposure.

Why Adjuster1 loses access: Adjuster1 was the previous owner. Once ownership is transferred to Adjuster2 (who is in a different group, 'Auto Team 2'), Adjuster1 no longer meets the criteria for ownership access. Unless Adjuster1 is explicitly added to the ACL manually or has 'Super User' privileges (not stated), they lose the automatic access rights associated with being the owner.

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