

SERFF Tracking Number:	HUMA-125727492	State:	Arkansas
Filing Company:	Humana Dental Insurance Company	State Tracking Number:	39562
Company Tracking Number:			
TOI:	H10I Individual Health - Dental	Sub-TOI:	H10I.000 Health - Dental
Product Name:	AR H1 Dental HPS- HDIC		
Project Name/Number:	/		

## Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: AR H1 Dental HPS- HDIC

TOI: H10I Individual Health - Dental

Sub-TOI: H10I.000 Health - Dental

Filing Type: Form

SERFF Tr Num: HUMA-125727492 State: ArkansasLH

SERFF Status: Closed

Co Tr Num:

Co Status:

Authors: Susan Ortiz, Amy Stroh,

Berthena Reed, Xai Xiong

Date Submitted: 07/09/2008

State Tr Num: 39562

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 08/12/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/12/2008

State Status Changed: 08/12/2008

Corresponding Filing Tracking Number:

Filing Description:

HumanaOne individual dental insurance application form.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

## Company and Contact

### Filing Contact Information

Xai Xiong, Application Project Analyst

xxiong@humana.com

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
Filing Company: Humana Dental Insurance Company State Tracking Number: 39562  
Company Tracking Number:  
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: AR H1 Dental HPS- HDIC  
Project Name/Number: /

2 Riverwood Place (262) 951-2633 [Phone]  
Waukesha, WI 53188

**Filing Company Information**

Humana Dental Insurance Company CoCode: 70580 State of Domicile: Wisconsin  
1100 Employer's Blvd Group Code: 119 Company Type:  
Green Bay, WI 54344 Group Name: State ID Number:  
(800) 558-4444 ext. [Phone] FEIN Number: 39-0714280  
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SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: AR H1 Dental HPS- HDIC  
Project Name/Number: /

## Filing Fees

Fee Required? Yes  
Fee Amount: \$20.00  
Retaliatory? No  
Fee Explanation: 1 form = \$20.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Dental Insurance Company	\$20.00	07/09/2008	21312695

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/12/2008	08/12/2008
Approved-Closed	Rosalind Minor	07/09/2008	07/09/2008

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
HumanaOne Individual Dental Insurance Application	Form	Xai Xiong	07/25/2008	07/25/2008

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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Company Tracking Number:  
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: AR H1 Dental HPS- HDIC  
Project Name/Number: /

## Disposition

Disposition Date: 08/12/2008

Implementation Date:

Status: Approved-Closed

Comment: This filing is being approved effective on 8/12/08. The filing reflects the change to a typographical error on the original filing.

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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 Company Tracking Number:  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: AR H1 Dental HPS- HDIC  
 Project Name/Number: /

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Statement of Variability	Approved-Closed	Yes
<b>Form (revised)</b>	HumanaOne Individual Dental Insurance Application	Approved-Closed	Yes
<b>Form</b>	HumanaOne Individual Dental Insurance Application	Withdrawn	No

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
Filing Company: Humana Dental Insurance Company State Tracking Number: 39562  
Company Tracking Number:  
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: AR H1 Dental HPS- HDIC  
Project Name/Number: /

## Disposition

Disposition Date: 07/09/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
 Filing Company: Humana Dental Insurance Company State Tracking Number: 39562  
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Statement of Variability	Approved-Closed	Yes
<b>Form (revised)</b>	HumanaOne Individual Dental Insurance Application	Approved-Closed	Yes
<b>Form</b>	HumanaOne Individual Dental Insurance Application	Withdrawn	No

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
 Filing Company: Humana Dental Insurance Company State Tracking Number: 39562  
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: AR H1 Dental HPS- HDIC  
 Project Name/Number: /

**Amendment Letter**

Amendment Date:  
 Submitted Date: 07/25/2008

**Comments:**

Typographical error identified in the form name and has been updated. No other changes/updates made to the form. Attached is the revised form.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GN-71017 7/2008	Application/EHumanaOne Enrollment Form	Individual Dental Insurance Application	Initial				40	GN-71017-0708.pdf

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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 Product Name: AR H1 Dental HPS- HDIC  
 Project Name/Number: /

## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	GN-71017	Application/HumanaOne	Initial		40	GN-71017-
Closed	7/2008	Enrollment Individual Dental Form Insurance Application				0708.pdf

# HumanaOne Individual Dental Insurance Application

Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."



Date of Dental Application: \_\_\_/\_\_\_/\_\_\_\_\_

## Dental Coverage Options

I choose to add dental insurance to my current medical plan for all enrolled dependents.

*Dental coverage will be added to your medical plan for all medical enrolled dependents upon renewal.*

## Payment Authorization & Billing Information

Your dental payment authorization and billing information will remain the same as previously selected for medical coverage.

## Primary Applicant/Insured Information

If child-only coverage is requested, the youngest child is the Primary Applicant/Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /	
Home address (not PO Box)			City	State	Zip code
Social Security #		Country or State of birth			
Policyholder name if different than Primary Applicant (applicable for child-only application)					

## Agreement and Signature

### True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are true and complete.
- I have received and reviewed any state or federal required disclosures.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the Policy. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the payment options section on the HumanaOne individual medical insurance application.
- Any misrepresentation on this application may be used by Humana during the first [0-2] policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial.

This document, together with any supplements, will form part of and be the basis for any Policy issued.

**Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud. If you decide not to sign this agreement, we will decline to enroll you in a dental plan or to give you dental benefits.**

Primary Applicant or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_ (if covered dependent)

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

**[Dental] [products] insured by [HumanaDental Insurance Company]**

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: AR H1 Dental HPS- HDIC  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-125727492 State: Arkansas  
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 Company Tracking Number:  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: AR H1 Dental HPS- HDIC  
 Project Name/Number: /

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	07/09/2008
<b>Comments:</b>	See Attached.			
<b>Attachment:</b>	AR HDIC Certificate of Readability 7-08.pdf			
<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	07/09/2008
<b>Bypass Reason:</b>	The application is the form being submitted for review and approval.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Outline of Coverage	<b>Review Status:</b>	Approved-Closed	07/09/2008
<b>Bypass Reason:</b>	Does not apply.			
<b>Comments:</b>				
<b>Satisfied -Name:</b>	Cover Letter	<b>Review Status:</b>	Approved-Closed	07/09/2008
<b>Comments:</b>	See Attached.			
<b>Attachment:</b>	AR Cover Letter HDIC 7-08.pdf			
<b>Satisfied -Name:</b>	Statement of Variability	<b>Review Status:</b>	Approved-Closed	07/09/2008
<b>Comments:</b>	See Attached.			
<b>Attachment:</b>	Statement of Variability _12-7-07_.pdf			



**HUMANA DENTAL INSURANCE COMPANY**

**CERTIFICATION**

**RE: Form AR-71017 7/2008**

I hereby certify, to the best of my knowledge and belief, that the enclosed form(s) comply(ies) with the requirements of Arkansas Insurance Code 23-80-206.

**Form Number(s)**

Form AR-71017 7/2008

**Flesch Test Reading Ease Score**

40

**Signed by:**

A handwritten signature in black ink, appearing to read "Gerald L. Ganoni", written over a solid horizontal line.

Gerald L. Ganoni  
President

**Date:** July 9, 2008



June 26, 2008

Arkansas Department of Insurance  
1200 West Third Street  
Little Rock, AR 72201-1904

**RE: HUMANA DENTAL INSURANCE COMPANY**  
**Individual Insurance Application Filing**  
**Form Numbers: AR-71017 7/2008**  
**NAIC #70580**  
**FEIN #39-0714280**

Dear Sir or Madam:

We are enclosing the above-referenced form(s) for your review and approval. This is a new filing; the enclosed form(s) do not replace or supersede any like form(s) previously filed. These form(s) are for use in the individual market. The form(s) are being filed for general use with all approved policy series.

This application will be used to offer members with an existing medical policy the opportunity to add dental coverage if they had not previously elected to take the coverage.

Included with this submission are the following documents:

- Statement of Variability; and
- Certificate of Readability

To the best of our knowledge, we believe the attached form(s) satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me by phone at (800) 289-0260, extension 2633, by fax at (920) 632-0479, or by e-mail at [xxiong@humana.com](mailto:xxiong@humana.com).

Sincerely,

A handwritten signature in cursive script that reads "Xai Xiong".

Xai Xiong  
Contract Analyst  
Humana Insurance Company

Enclosures

### **Statement of Variability**

- All bracketed numbers are variable. Numbers within a section or provision are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
- Bracketed paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular product.
- Definitions may vary to the extent that such definition may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Product information, including items which customarily vary according to the policyholder's specific plan of insurance, is bracketed.
- Additional fields may be added to an application within an existing bracketed section for the purpose of offering new products or benefits subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular sections.
- Bracketed instructional text varies to the extent that such text may be added, modified, included, omitted or transferred to another page subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular section(s) on which it intends to provide instruction.
- Bracketed demographic information varies to the extent that such information may be added, modified, included, omitted or transferred to another page subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular section(s).

We also reserve the right to amend the attached form(s) to fix any minor clerical errors that may have unintentionally gone unnoticed prior to submitting for approval, to amend the language to clarify the intent, and to make minor help text revisions as needed to clarify instructions for completion of the application, all within the confines of the law.

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 Project Name/Number: /

## Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	HumanaOne Individual Dental Insurance Application	07/09/2008	AR-71017-0708.pdf

# HumanaOne Individual Dental Insurance Application

Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."



Date of Dental Application: \_\_\_/\_\_\_/\_\_\_\_\_

## Dental Coverage Options

I choose to add dental insurance to my current medical plan for all enrolled dependents.

*Dental coverage will be added to your medical plan for all medical enrolled dependents upon renewal.*

## Payment Authorization & Billing Information

Your dental payment authorization and billing information will remain the same as previously selected for medical coverage.

## Primary Applicant/Insured Information

If child-only coverage is requested, the youngest child is the Primary Applicant/Insured. Questions must be filled out by custodial parent or legal guardian.

First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /	
Home address (not PO Box)			City	State	Zip code
Social Security #		Country or State of birth			
Policyholder name if different than Primary Applicant (applicable for child-only application)					

## Agreement and Signature

### True and Complete Acknowledgment:

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers are true and complete.
- I have received and reviewed any state or federal required disclosures.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the Policy. Acceptance of premium and fees does not guarantee coverage.
- To automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected under the payment options section on the HumanaOne individual medical insurance application.
- Any misrepresentation on this application may be used by Humana during the first [0-2] policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial.

This document, together with any supplements, will form part of and be the basis for any Policy issued.

**Any person who submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud. If you decide not to sign this agreement, we will decline to enroll you in a dental plan or to give you dental benefits.**

Primary Applicant or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_

Relationship of Legal Guardian \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_ (if covered dependent)

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana".

**[Dental] [products] insured by [HumanaDental Insurance Company]**