

SERFF Tracking Number: HUMA-126005867 State: Arkansas  
Filing Company: Humana Dental Insurance Company State Tracking Number: 41901  
Company Tracking Number:  
TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental  
Product Name: Humana Dental Insurance Company  
Project Name/Number: /

## Filing at a Glance

Company: Humana Dental Insurance Company

Product Name: Humana Dental Insurance Company SERFF Tr Num: HUMA-126005867 State: ArkansasLH

Company

TOI: H10I Individual Health - Dental

SERFF Status: Closed

State Tr Num: 41901

Sub-TOI: H10I.000 Health - Dental

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Latunia Riley

Disposition Date: 01/28/2009

Date Submitted: 01/26/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/28/2009

Deemer Date:

State Status Changed: 01/28/2009

Corresponding Filing Tracking Number:

Filing Description:

New Enrollment Application

## Company and Contact

### Filing Contact Information

Latunia Riley, Contract Analyst

lriley2@humana.com

SERFF Tracking Number: HUMA-126005867 State: Arkansas  
Filing Company: Humana Dental Insurance Company State Tracking Number: 41901  
Company Tracking Number:  
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: Humana Dental Insurance Company  
Project Name/Number: /

2 Riverwood Place (262) 951-2617 [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-126005867 State: Arkansas  
Filing Company: Humana Dental Insurance Company State Tracking Number: 41901  
Company Tracking Number:  
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
Product Name: Humana Dental Insurance Company  
Project Name/Number: /

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Dental Insurance Company	\$50.00	01/26/2009	25251654

SERFF Tracking Number: HUMA-126005867

State: Arkansas

Filing Company: Humana Dental Insurance Company

State Tracking Number: 41901

Company Tracking Number:

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: Humana Dental Insurance Company

Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/28/2009	01/28/2009

SERFF Tracking Number: HUMA-126005867

State: Arkansas

Filing Company: Humana Dental Insurance Company

State Tracking Number: 41901

Company Tracking Number:

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: Humana Dental Insurance Company

Project Name/Number: /

## Disposition

Disposition Date: 01/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126005867 State: Arkansas  
 Filing Company: Humana Dental Insurance Company State Tracking Number: 41901  
 Company Tracking Number:  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Humana Dental Insurance Company  
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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	NAIC Transmittal Doc	Approved-Closed	Yes
<b>Supporting Document</b>	AR Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Statetment Variability Enrollment Form	Approved-Closed	Yes
<b>Form</b>	HumanaOne PPO Annual Max Plan Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: HUMA-126005867 State: Arkansas  
 Filing Company: Humana Dental Insurance Company State Tracking Number: 41901  
 Company Tracking Number:  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: Humana Dental Insurance Company  
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## Form Schedule

**Lead Form Number:** AR-71005 10/2008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-	AR-71005	Application/	HumanaOne PPO	Initial			AR-71005-
Closed	10/2008	Enrollment	Annual Max Plan				1008.pdf
		Form	Enrollment Form				

# HumanaOne PPO Annual Max Plan Enrollment Form



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."  
If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the enrollment form.

Date of form: \_\_\_/\_\_\_/\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

[Arkansas]

- This form is for:
- New Business (First time enrollee)
  - Reinstatement (Reapplication)
  - Change/modification to Existing Policy or Plan  
Reason for change \_\_\_\_\_  
Change/Modification to Existing Policy or Plan # \_\_\_\_\_

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Deductible Amount:  [\$1,000]  [\$2,000]  [\$3,000]

#### PPO Plan 50/30

(Please select each of the following for the PPO Plan 50/30)

**Please Note:** Some options may not be available with all deductibles, or annual maximums.

**1. Calendar Year Annual Maximum:**

- [\$100,000]  [\$250,000]

**2. Calendar Year Annual Outpatient Maximum:**

- [\$5,000]  
 [\$10,000] (Available only with [\$250,000] annual maximum)

**3. Supplemental Accident Benefit:**

- [\$500]  [\$1,000]

#### PPO Plan 75/55

(Please select each of the following for the PPO Plan 75/55)

**Please Note:** Some options may not be available with all deductibles, or annual maximums.

**1. Calendar Year Annual Maximum:**

- [\$100,000]  [\$250,000]

**2. Calendar Year Annual Outpatient Maximum:**

- [\$5,000]  
 [\$10,000] (Available only with [\$250,000] annual maximum)

**3. Supplemental Accident Benefit:**

- [\$500]  [\$1,000]

#### Dental Coverage

**Please note:** You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

#### Important information about the Health Insurance Plan you are about to apply for

I have reviewed the plan information and understand the HumanaOne PPO Annual Max plan has calendar year policy limits for all covered services, for outpatient services, and for pharmacy services (where applicable). Expenses applied to the outpatient and pharmacy calendar year limits will also be applied to the all covered services calendar year limit. I understand any costs incurred for services above the calendar year limits are entirely my responsibility. I understand Humana has other plans available that do not have calendar year limits.

## Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for insured and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

#### Primary Insured:

[\$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

Term Life Plan (Minimum selection is [\$0-25,000] and [\$0-1,000] increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  [10] years  [15] years  [20] years

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

#### Spouse:

[\$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

Term Life Plan (Minimum selection is [\$0-25,000] and [\$0-1,000] increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  [10] years  [15] years  [20] years

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

## Primary Insured Information

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

First name	MI	Last name	Height	Weight	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		Email		
Type of business or industry	Occupation		Home phone # ( )		Daytime phone # ( )	
Mailing address (if different from home address)			City	State	Zip code	
Certificateholder name if different than Primary Insured (applicable for child-only enrollment form)						

## Parent or Guardian Information

Please complete this section if Primary Insured is under [0-18] years of age.

First name	MI	Last name	Email			
Home address (not PO Box)			City	State	Zip code	
Home phone # ( )		Daytime phone # ( )		Relationship to child(ren)		

## Family Information

Please complete only if your spouse and/or dependent children are enrolling for coverage. Attach an additional family information sheet if necessary.

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Country or State of birth		Spouse's type of business or industry		Spouse's occupation		
Social Security #			Email			
<b>Dependent 1</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>Dependent 2</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>Dependent 3</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>Dependent 4</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

## Existing Coverage

**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

### • Existing Health Coverage

If you are enrolling for health coverage, please provide the status of current coverage, including Humana, for each person enrolling.

If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No  Yes Do you or anyone enrolling for coverage have any health insurance coverage currently in force?]

[• If yes, please supply the following for all persons enrolling on the plan:

Name(s) of covered persons

Insurance Carrier Name

Effective Date

\_\_ / \_\_ / \_\_\_\_

• Existing Dental Coverage

[1.  No  Yes Does anyone enrolling for coverage currently have or had any dental coverage within the last [1-24] months?]

[• If yes, please supply the following for all persons enrolling for coverage on the plan:

Name(s) Effective Date \_\_\_/\_\_\_/\_\_\_\_
Insurance Carrier Name Termination Date \_\_\_/\_\_\_/\_\_\_\_
Name(s) Effective Date \_\_\_/\_\_\_/\_\_\_\_
Insurance Carrier Name Termination Date \_\_\_/\_\_\_/\_\_\_\_]

[2.  No  Yes Will the insurance coverage enrolled for be used to replace existing dental coverage?]

• Existing Life Coverage

Primary Insured:

[1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?]

[• If yes, please supply the following information:

Company name Amount \$ Plan # ]

Spouse:

[1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?]

[• If yes, please supply the following information:

Company name Amount \$ Plan # ]

Eligibility & Health Status

Please answer for all individuals enrolling for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents enrolling for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any eligibility or health information may result in your plan being modified or terminated, back to your original effective date.

[1.  No  Yes Is anyone enrolling for coverage a citizen of a country other than the United States?]

[• If yes: Name(s): ]

Has anyone enrolling for coverage:

[2.  No  Yes Experienced weight gain or loss of more than [0-100] pounds in the past [1-24] months?]

[3. Within the past [1-24] months, has the primary insured or spouse enrolling for coverage used any tobacco product?]

[Primary Insured:  No  Yes]

[Spouse:  No  Yes]

[4.  No  Yes Does anyone enrolling for coverage plan to participate in any dangerous or extreme sport activities?]

[5.  No  Yes Is the primary insured, spouse or any of their dependents pregnant or an expectant mother or father?]

Within the past [1-5] years, has anyone enrolling for coverage:

[6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?]

[7.  No  Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or HIV?]

[8.  No  Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?]

[9.  No  Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?]

[10.  No  Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?]

[11.  No  Yes Had or been advised to have inpatient or outpatient surgery, that is complete or has not been completed?]

[12.  No  Yes Consulted, been advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?]

## Eligibility & Health Status continued

[13. **Within the past [1-5] years**, has anyone enrolling for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack]	[M. <input type="checkbox"/> No <input type="checkbox"/> Yes Behavioral, Emotional, Mental or Nervous Disorder]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension]	[N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides]	[O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind]	[P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar]	[Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke]	[R. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp]
[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis]	[S. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia]
[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure]	[T. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis]
[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches]	[U. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods Screws or Prosthesis]
[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis]	[V. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder]
[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea]	[W. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect]
[L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression]	]

[14. **Within the past [1-5] years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas]	[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys]	[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine]	[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs]	[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses]	]

[15. **Within the past [1-5] years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System]	[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System]	[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System]	[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System]]

[16.  No  Yes Has anyone enrolling for coverage seen a health care provider or specialist for any reason (including routine visits) or symptom not previously disclosed above?]

[17.  No  Yes Within the past [1-24] months, has anyone enrolling for coverage been advised to take or taken any prescription medications or injections?]

## Additional Eligibility or Health Status Question Information

To be completed if anyone enrolling for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary insured or legal representative and/or spouse (if enrolling).

[Question #	Letter	Person treated	Condition
Details:			]
[Question #	Letter	Person treated	Condition
Details:			]
[Question #	Letter	Person treated	Condition
Details:			]

## Payment Authorization & Billing Information

If you are paying for the plan, you must complete 1 & 2 below. If someone other than yourself will be paying for the plan, please fill out the separate alternate payor information page. Agent/Producer, Employer payments are not accepted.

Quoted Premium Payment Amount: \$ \_\_\_\_\_

Association Dues: [\$1-8] Monthly (non-refundable)

### 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

#### Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa  Mastercard

Card # \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_

Cardholder's name \_\_\_\_\_

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

#### One-time Automatic Bank Withdrawal

Please print.

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw initial premium payment from the account above.

### 2. Subsequent Premium Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

**Direct Bill, if selected a fee of \$ [ \_\_\_\_\_ ] will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal**

Monthly billing

Quarterly billing

Semi-Annual billing

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

## Agent / Producer Information

This section to be completed by Agent or Producer.

#### 1. Agent/Agency of Record (for commissions and correspondence)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 1. Writing Agent / Producer:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Agent/Agency of Record (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Writing Agent / Producer (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### Agent replacement question:

[Will this plan replace or change any existing life insurance policy(s) and/or annuity(s)?  No  Yes]

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other plan literature.

Writing Agent's Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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.
- Neither I nor my company sales representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- This plan enrolled for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums.
- If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. 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 authorization and payment options section.
- Any misrepresentation on this enrollment form may be used by Humana during the first [0-2] plan 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.
- By signing below, I agree to terminate existing coverage if approved.
- As a parent or legal guardian of a dependent [0-18] years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary health information from my dependent in order to fully and truthfully complete this enrollment form.

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

**Any person who submits an enrollment form 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 medical plan or to give you medical benefits.**

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

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

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

**New Association Enrollment:** The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required in order to be eligible for health insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

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

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

**[Medical] and [Life] [products] insured by [Humana Insurance Company]  
[Dental] [products] insured by [HumanaDental Insurance Company]**



## Alternate Payor Information

If someone other than the primary insured will be paying for the plan, please complete the following information and 1 & 2 below.

### Who will be paying for this plan(s)?

First name	MI	Last name	Home phone # ( )	Daytime phone # ( )
Home address (not PO Box)		City	State	Zip code

Quoted Premium Payment Amount: \$ \_\_\_\_\_

Association Dues: [\$1-8] Monthly (non-refundable)

## 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

### Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa       Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

### One-time Automatic Bank Withdrawal

Please print.

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw initial premium payment from the account above.

## 2. Subsequent Premium Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

**Direct Bill, if selected a fee of \$ [      ] will apply.**       **Automatic Bank Withdrawal**

Monthly billing

Quarterly billing

Semi-Annual billing

Monthly billing

Quarterly billing

Semi-Annual billing

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

Alternate Payor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

SERFF Tracking Number: HUMA-126005867

State: Arkansas

Filing Company: Humana Dental Insurance Company

State Tracking Number: 41901

Company Tracking Number:

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: Humana Dental Insurance Company

Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126005867

State: Arkansas

Filing Company: Humana Dental Insurance Company

State Tracking Number: 41901

Company Tracking Number:

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: Humana Dental Insurance Company

Project Name/Number: /

## Supporting Document Schedules

<b>Satisfied -Name:</b> Flesch Certification	<b>Review Status:</b> Approved-Closed	01/28/2009
<b>Comments:</b>		
<b>Attachment:</b> AR Certificate of Readability.pdf		
<b>Satisfied -Name:</b> Application	<b>Review Status:</b> Approved-Closed	01/28/2009
<b>Comments:</b>		
<b>Attachment:</b> AR-71005-1008.pdf		
<b>Bypassed -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	01/28/2009
<b>Bypass Reason:</b> Not Applicable to filing		
<b>Comments:</b>		
<b>Satisfied -Name:</b> NAIC Transmittal Doc	<b>Review Status:</b> Approved-Closed	01/28/2009
<b>Comments:</b>		
<b>Attachment:</b> AR NAIC Signed Transmittal Doc.pdf		
<b>Satisfied -Name:</b> AR Cover Letter	<b>Review Status:</b> Approved-Closed	01/28/2009
<b>Comments:</b>		
<b>Attachment:</b> AR Filing Cover Letter.pdf		
<b>Satisfied -Name:</b> Statetment Variability Enrollment Form	<b>Review Status:</b> Approved-Closed	01/28/2009

*SERFF Tracking Number: HUMA-126005867*

*State: Arkansas*

*Filing Company: Humana Dental Insurance Company*

*State Tracking Number: 41901*

*Company Tracking Number:*

*TOI: H101 Individual Health - Dental*

*Sub-TOI: H101.000 Health - Dental*

*Product Name: Humana Dental Insurance Company*

*Project Name/Number: /*

**Comments:**

**Attachment:**

Statement of Variability.Enrollment Form.pdf



## CERTIFICATION

**RE: Form: AR-71005 10/2008**

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)**

AR-71005 10/08

**Flesch Test Reading Ease Score**

40.7

**Signed by:**



\_\_\_\_\_  
Steve DeRaleau  
Vice President

**Date:** January 26, 2009

# HumanaOne PPO Annual Max Plan Enrollment Form



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."  
If you have not had continuous health coverage within the past 63 days, you must choose an effective date that is 30-45 days past the date of the enrollment form.

Date of form: \_\_\_/\_\_\_/\_\_\_ Requested Effective Date: \_\_\_/\_\_\_/\_\_\_

[Arkansas]

- This form is for:
- New Business (First time enrollee)
  - Reinstatement (Reapplication)
  - Change/modification to Existing Policy or Plan  
Reason for change \_\_\_\_\_  
Change/Modification to Existing Policy or Plan # \_\_\_\_\_

## Health & Dental Coverage Options

### Health Coverage

Please complete this section when selecting a health plan.

Deductible Amount:  [\$1,000]  [\$2,000]  [\$3,000]

#### PPO Plan 50/30

(Please select each of the following for the PPO Plan 50/30)

**Please Note:** Some options may not be available with all deductibles, or annual maximums.

**1. Calendar Year Annual Maximum:**

- [\$100,000]  [\$250,000]

**2. Calendar Year Annual Outpatient Maximum:**

- [\$5,000]  
 [\$10,000] (Available only with [\$250,000] annual maximum)

**3. Supplemental Accident Benefit:**

- [\$500]  [\$1,000]

#### PPO Plan 75/55

(Please select each of the following for the PPO Plan 75/55)

**Please Note:** Some options may not be available with all deductibles, or annual maximums.

**1. Calendar Year Annual Maximum:**

- [\$100,000]  [\$250,000]

**2. Calendar Year Annual Outpatient Maximum:**

- [\$5,000]  
 [\$10,000] (Available only with [\$250,000] annual maximum)

**3. Supplemental Accident Benefit:**

- [\$500]  [\$1,000]

#### Dental Coverage

**Please note:** You may purchase dental coverage if health coverage is chosen. If dental is selected, it will be approved if the health coverage is approved. If you are changing or modifying an existing/approved policy or plan, dental is only available at your anniversary.

#### Important information about the Health Insurance Plan you are about to apply for

I have reviewed the plan information and understand the HumanaOne PPO Annual Max plan has calendar year policy limits for all covered services, for outpatient services, and for pharmacy services (where applicable). Expenses applied to the outpatient and pharmacy calendar year limits will also be applied to the all covered services calendar year limit. I understand any costs incurred for services above the calendar year limits are entirely my responsibility. I understand Humana has other plans available that do not have calendar year limits.

## Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for insured and/or spouse.

Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

#### Primary Insured:

[\$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

Term Life Plan (Minimum selection is [\$0-25,000] and [\$0-1,000] increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  [10] years  [15] years  [20] years

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

#### Spouse:

[\$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

Term Life Plan (Minimum selection is [\$0-25,000] and [\$0-1,000] increments)

Term life insurance amount: \$ \_\_\_\_\_

Term length:  [10] years  [15] years  [20] years

Primary beneficiary name	
Relationship	Benefit %
Contingent beneficiary name	
Relationship	Benefit %

## Primary Insured Information

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

First name	MI	Last name	Height	Weight	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	Email			
Type of business or industry	Occupation		Home phone # ( )	Daytime phone # ( )		
Mailing address (if different from home address)			City	State	Zip code	
Certificateholder name if different than Primary Insured (applicable for child-only enrollment form)						

## Parent or Guardian Information

Please complete this section if Primary Insured is under [0-18] years of age.

First name	MI	Last name	Email			
Home address (not PO Box)			City	State	Zip code	
Home phone # ( )	Daytime phone # ( )		Relationship to child(ren)			

## Family Information

Please complete only if your spouse and/or dependent children are enrolling for coverage. Attach an additional family information sheet if necessary.

<b>Spouse</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Country or State of birth	Spouse's type of business or industry			Spouse's occupation		
Social Security #			Email			
<b>Dependent 1</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>Dependent 2</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>Dependent 3</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						
<b>Dependent 4</b> First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth date / /
Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes						

## Existing Coverage

**IMPORTANT: DO NOT** cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

### • Existing Health Coverage

If you are enrolling for health coverage, please provide the status of current coverage, including Humana, for each person enrolling.

If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

No  Yes Do you or anyone enrolling for coverage have any health insurance coverage currently in force?]

[• If yes, please supply the following for all persons enrolling on the plan:

Name(s) of covered persons

Insurance Carrier Name

Effective Date

\_\_ / \_\_ / \_\_\_\_

• Existing Dental Coverage

[1.  No  Yes Does anyone enrolling for coverage currently have or had any dental coverage within the last [1-24] months?]

[• If yes, please supply the following for all persons enrolling for coverage on the plan:

Name(s) Effective Date \_\_\_/\_\_\_/\_\_\_\_
Insurance Carrier Name Termination Date \_\_\_/\_\_\_/\_\_\_\_
Name(s) Effective Date \_\_\_/\_\_\_/\_\_\_\_
Insurance Carrier Name Termination Date \_\_\_/\_\_\_/\_\_\_\_]

[2.  No  Yes Will the insurance coverage enrolled for be used to replace existing dental coverage?]

• Existing Life Coverage

Primary Insured:

[1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?]

[• If yes, please supply the following information:

Company name Amount \$ Plan # ]

Spouse:

[1.  No  Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2.  No  Yes Will the insurance coverage enrolled for be used to replace any existing life and/or annuity coverage?]

[• If yes, please supply the following information:

Company name Amount \$ Plan # ]

Eligibility & Health Status

Please answer for all individuals enrolling for coverage.

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents enrolling for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any eligibility or health information may result in your plan being modified or terminated, back to your original effective date.

[1.  No  Yes Is anyone enrolling for coverage a citizen of a country other than the United States?]

[• If yes: Name(s): ]

Has anyone enrolling for coverage:

[2.  No  Yes Experienced weight gain or loss of more than [0-100] pounds in the past [1-24] months?]

[3. Within the past [1-24] months, has the primary insured or spouse enrolling for coverage used any tobacco product?]

[Primary Insured:  No  Yes]

[Spouse:  No  Yes]

[4.  No  Yes Does anyone enrolling for coverage plan to participate in any dangerous or extreme sport activities?]

[5.  No  Yes Is the primary insured, spouse or any of their dependents pregnant or an expectant mother or father?]

Within the past [1-5] years, has anyone enrolling for coverage:

[6.  No  Yes Been denied for health or life insurance or had their health coverage ridered, rated or rescinded?]

[7.  No  Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or HIV?]

[8.  No  Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?]

[9.  No  Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?]

[10.  No  Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?]

[11.  No  Yes Had or been advised to have inpatient or outpatient surgery, that is complete or has not been completed?]

[12.  No  Yes Consulted, been advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?]

## Eligibility & Health Status continued

[13. **Within the past [1-5] years**, has anyone enrolling for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain or Heart Attack]	[M. <input type="checkbox"/> No <input type="checkbox"/> Yes Behavioral, Emotional, Mental or Nervous Disorder]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure or Hypertension]	[N. <input type="checkbox"/> No <input type="checkbox"/> Yes Eating Disorder]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol or Triglycerides]	[O. <input type="checkbox"/> No <input type="checkbox"/> Yes Developmental Disorder or Delay]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Cancer or Tumor of any kind]	[P. <input type="checkbox"/> No <input type="checkbox"/> Yes Human Papilloma Virus or Sexually Transmitted Disease]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes or High Blood Sugar]	[Q. <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke]	[R. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp]
[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis]	[S. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia]
[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure]	[T. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis]
[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches]	[U. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods Screws or Prosthesis]
[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis]	[V. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder]
[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea]	[W. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect]
[L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression]	]

[14. **Within the past [1-5] years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Gallbladder, Liver or Pancreas]	[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys]	[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine]	[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs]	[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Eyes, Ears, Nose, Throat or Sinuses]	]

[15. **Within the past [1-5] years**, has anyone enrolling for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood Vessels, Heart or Circulatory System]	[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary System]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Blood, Gland, Pituitary, Thyroid or Lymph System]	[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal System]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Brain or Nervous System]	[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory System]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Digestive System]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Reproductive System]]

[16.  No  Yes Has anyone enrolling for coverage seen a health care provider or specialist for any reason (including routine visits) or symptom not previously disclosed above?]

[17.  No  Yes Within the past [1-24] months, has anyone enrolling for coverage been advised to take or taken any prescription medications or injections?]

## Additional Eligibility or Health Status Question Information

To be completed if anyone enrolling for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary insured or legal representative and/or spouse (if enrolling).

[Question #	Letter	Person treated	Condition
Details:			]

[Question #	Letter	Person treated	Condition
Details:			]

[Question #	Letter	Person treated	Condition
Details:			]

## Payment Authorization & Billing Information

If you are paying for the plan, you must complete 1 & 2 below. If someone other than yourself will be paying for the plan, please fill out the separate alternate payor information page. Agent/Producer, Employer payments are not accepted.

Quoted Premium Payment Amount: \$ \_\_\_\_\_

Association Dues: [\$1-8] Monthly (non-refundable)

### 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

#### Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa  Mastercard

Card # \_\_\_\_\_

Expiration date \_\_\_\_\_ / \_\_\_\_\_

Cardholder's name \_\_\_\_\_

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

#### One-time Automatic Bank Withdrawal

Please print.

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw initial premium payment from the account above.

### 2. Subsequent Premium Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

**Direct Bill, if selected a fee of \$ [ \_\_\_\_\_ ] will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal**

Monthly billing

Quarterly billing

Semi-Annual billing

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

## Agent / Producer Information

This section to be completed by Agent or Producer.

#### 1. Agent/Agency of Record (for commissions and correspondence)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 1. Writing Agent / Producer:

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Commission split:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Agent/Agency of Record (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### 2. Writing Agent / Producer (for split-commissions)

Name (print) \_\_\_\_\_

Humana Agent # \_\_\_\_\_

Percentage of sales:  No  Yes

If yes, percentage \_\_\_\_\_ (Total should equal 100%)

#### Agent replacement question:

[Will this plan replace or change any existing life insurance policy(s) and/or annuity(s)?  No  Yes]

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the insuring entity, or one of its subsidiaries. These provisions are available to me and the primary insured in the benefit summary document or other plan literature.

Writing Agent's Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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.
- Neither I nor my company sales representative has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- This plan enrolled for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums.
- If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. 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 authorization and payment options section.
- Any misrepresentation on this enrollment form may be used by Humana during the first [0-2] plan 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.
- By signing below, I agree to terminate existing coverage if approved.
- As a parent or legal guardian of a dependent [0-18] years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary health information from my dependent in order to fully and truthfully complete this enrollment form.

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

**Any person who submits an enrollment form 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 medical plan or to give you medical benefits.**

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

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

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

**New Association Enrollment:** The Association, Peoples' Benefit Alliance, is a membership organization that provides educational information and discounts on goods and services to its members. Membership in the Association is required in order to be eligible for health insurance coverage. The Association benefits information will be sent under separate cover. By signing below, you are requesting enrollment in the Association.

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

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

**[Medical] and [Life] [products] insured by [Humana Insurance Company]  
[Dental] [products] insured by [HumanaDental Insurance Company]**



## Alternate Payor Information

If someone other than the primary insured will be paying for the plan, please complete the following information and 1 & 2 below.

### Who will be paying for this plan(s)?

First name	MI	Last name	Home phone # ( )	Daytime phone # ( )
Home address (not PO Box)		City	State	Zip code

Quoted Premium Payment Amount: \$ \_\_\_\_\_

Association Dues: [\$1-8] Monthly (non-refundable)

## 1. Initial Premium Payment Options

Initial premium payment must total one month's premium for each product selected. Please choose your preference for payment of first month's premium. Please complete credit card or one-time bank withdrawal below.

### Credit Card Payment

Initial payment for each product enrolled for will be drafted separately against your account.

Visa       Mastercard

Card # \_\_\_\_\_

Expiration date      /

Cardholder's name \_\_\_\_\_

I authorize Humana to draw initial premium payment from my VISA / Mastercard account.

### One-time Automatic Bank Withdrawal

Please print.

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw initial premium payment from the account above.

## 2. Subsequent Premium Payment Options

Please indicate billing preference. If choosing automatic bank withdrawal, please complete the section to the right.

**Direct Bill, if selected a fee of \$ [      ] will apply.**

Monthly billing

Quarterly billing

Semi-Annual billing

**Automatic Bank Withdrawal**

Monthly billing

Quarterly billing

Semi-Annual billing

Account holder's name \_\_\_\_\_

Bank name \_\_\_\_\_

Routing # \_\_\_\_\_

Account # \_\_\_\_\_

I authorize Humana to draw premium payment from the account above until this authorization is revoked by me.

Alternate Payor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Life, Accident & Health, Annuity, Credit Transmittal Document

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>
	<b>State Tracking ID</b>

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Humana Dental Insurance Company 1100 Employers Blvd Green Bay, WI 54.44	Wisconsin	Life, Disability and Annuities	119	70580	390714280	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Latunia Riley (Contract Analyst) Humana Insurance Company N19 W24133 Riverwood Drive Suite 250 Waukesha, WI 53188	800-289-0260 ext 2617	920-632-0029	lriley2@humana.com

<b>5.</b>	<b>Requested Filing Mode</b>	<input type="checkbox"/> Review & Approval <input checked="" type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6.</b>	<b>Company Tracking Number</b>	AR-71005 10/2008
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b> Previous file # _____
-----------	--

<b>8.</b>	<b>Market</b>	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise Group: <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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<b>9.</b>	<b>Type of Insurance</b>	H10I Individual Health-Dental
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<b>10.</b>	<b>Product Coding Matrix Filing Code</b>	H10L.000 Health-Dental
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<b>11.</b>	<b>Submitted Documents</b>	<p><b><u>FORMS</u></b></p> <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other
		<p><b><u>Rates</u></b></p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate
		<p><input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____</p>
		<p><b><u>SUPPORTING DOCUMENTATION</u></b></p> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input checked="" type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____



<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		AR-71005 10/2008
<b>This filing corresponds to rate filing company tracking number</b>		N/A

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Humana One PPO Annual Max Plan Enrollment Form Enrollment Form	AR-71005 10/2008	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

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18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number		AR-71005 10/2008		
Overall percentage rate indication (when applicable)		N/A		
Overall percentage rate impact for this filing		N/A %		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

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January 26, 2009

Life and Health Division  
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-71005 10/2008**  
**NAIC #70580**  
**FEIN #39-0714280**

Dear Sir or Madam:

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

This application will be used to support our currently marketed products in your state.

To the best of our knowledge, we believe the attached forms 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 2617, by fax at (920) 632-0029, or by e-mail at lriley2@humana.com.

Sincerely,

Latunia Riley  
Contract Analyst  
Humana Insurance Company

Enclosures

## **Statement of Variability for Enrollment Forms**

### **Bracketed Sections**

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.
2. Bracketed sections are identified by green brackets.

**NOTE:** Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.
4. 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 any statutory or regulatory requirements.
  - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.
5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

### **Bracketed Numbers**

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.
  - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.
  - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.
2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.
3. Bracketed numbers will include the minimum and maximum ranges.
4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

## **Bracketed Questions**

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).
2. Any bracketed variables within that question are subject to change.
3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

## **Instructions or Help Text**

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.
2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

## **Product Information**

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements
2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
  - prior approval of certificate or policy forms for the new products or benefits; and,
  - any statutory or regulatory requirements

## **Legal Entities**

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.
2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.
3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

## **Demographic Information**

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

## **Administrative Changes and Clerical Errors**

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.