

SERFF Tracking Number: HUMA-126299751 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 43574
Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Product Name: AR MAINT 7/2009
Project Name/Number: /

Filing at a Glance

Company: Humana Insurance Company

Product Name: AR MAINT 7/2009

TOI: H16I Individual Health - Major Medical

Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

Filing Type: Form

SERFF Tr Num: HUMA-126299751 State: Arkansas

SERFF Status: Closed-Approved- Closed State Tr Num: 43574

Co Tr Num:

State Status: Approved-Closed

Authors: Laura Kocken, Latunia Riley, Berthena Reed

Reviewer(s): Rosalind Minor

Disposition Date: 10/02/2009

Date Submitted: 09/24/2009

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/02/2009

Deemer Date:

Submitted By: Berthena Reed

Filing Description:

See attached cover letter

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 10/02/2009

Created By: Berthena Reed

Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Berthena Reed, Contract Analyst

breed2@humana.com

SERFF Tracking Number: HUMA-126299751 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 43574
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

Product Name: AR MAINT 7/2009
 Project Name/Number: /

2 Riverwood Place 262-951-2516 [Phone]
 N19 W24133 Riverwood Drive
 Waukesha, WI 53188

Filing Company Information

Humana Insurance Company CoCode: 73288 State of Domicile: Wisconsin
 1100 Employers Boulevard Group Code: 119 Company Type: Life & Health
 Green Bay, WI 54344 Group Name: State ID Number:
 (800) 558-4444 ext. [Phone] FEIN Number: 39-1263473

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	09/24/2009	30801284

SERFF Tracking Number: HUMA-126299751 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 43574
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: AR MAINT 7/2009
 Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/02/2009	10/02/2009
Approved-Closed	Rosalind Minor	09/28/2009	09/28/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	HumanaOne Individual Insurance Application	Berthena Reed	10/01/2009	10/01/2009

SERFF Tracking Number: HUMA-126299751 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 43574
Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)
Product Name: AR MAINT 7/2009
Project Name/Number: /

Disposition

Disposition Date: 10/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

The application Form #AR-71002 9/2009 is approved effective on this date.

The rest of the submission will maintain its original approval date.

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126299751 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 43574
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
 (PPO)
 Product Name: AR MAINT 7/2009
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Arkansas Maintenance Rider	Approved-Closed	Yes
Form	Optional Mental Health Rider	Approved-Closed	Yes
Form	HumanaOne Individual Insurance Application	Approved-Closed	Yes

SERFF Tracking Number: HUMA-126299751 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 43574
Company Tracking Number:
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)
Product Name: AR MAINT 7/2009
Project Name/Number: /

Disposition

Disposition Date: 09/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126299751 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 43574
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider
 (PPO)
 Product Name: AR MAINT 7/2009
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Arkansas Maintenance Rider	Approved-Closed	Yes
Form	Optional Mental Health Rider	Approved-Closed	Yes
Form	HumanaOne Individual Insurance Application	Approved-Closed	Yes

SERFF Tracking Number: HUMA-126299751 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 43574
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: AR MAINT 7/2009
 Project Name/Number: /

Amendment Letter

Submitted Date: 10/01/2009

Comments:

Hello Rosalind,

I added the application to this filing as discussed in our email. The change is on the first page where we added a check box for the mental health rider. Thanks much!

Berthena

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
AR-71002-9/2009	Application/Enrollment Form	HumanaOne Individual Insurance Application	Initial					AR-71002-0909.pdf

SERFF Tracking Number: HUMA-126299751 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 43574
 Company Tracking Number:
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: AR MAINT 7/2009
 Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/28/2009	AR-70129 MAINT 8/2009	Policy/Cont Arkansas ract/Fratern Maintenance Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			AR-70129 MAINT 8- 2009.pdf
Approved-Closed 09/28/2009	AR-70129 8/2002 MENTAL	Policy/Cont Opitonal Mental ract/Fratern Health Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			AR Mental Health Rider IMM.pdf
Approved-Closed 10/02/2009	AR-71002 9/2009	Application/HumanaOne Enrollment Individual Insurance Form Application	Initial			AR-71002- 0909.pdf

ARKANSAS RIDER

HUMANA INSURANCE COMPANY

[Policyholder: [John Doe]]

[Policy Number: [xxxxxxx]]

[Effective Date: [xxxxxxxxx]]

This benefit rider is attached to and made a part of your policy. Except as modified below, all policy terms, conditions, and limitations apply.

The policy to which this rider is attached is amended as follows:

The **POLICY DEFINITIONS** section is amended as follows:

The following replaces the last paragraph in the definition of **Dependent**:

[A child is a full-time student when that child maintains full-time status at an accredited secondary school, college or university, as defined by that school, with no more than 4 months between school terms. However, a *dependent* child who takes a *medically necessary leave of absence* may continue to be eligible for coverage until the earlier of:

- One year after the first day of the *medically necessary leave of absence*; or
- The date coverage would otherwise terminate under this *certificate*.

We must receive written certification from the dependent child's health care practitioner that the dependent child has a bodily injury or sickness that requires a medically necessary leave of absence. In no event will coverage continue beyond the limiting age.]

The following definition is added:

[**Medically necessary leave of absence** means a leave of absence for a *dependent* child who is no longer enrolled for sufficient course credits to maintain full-time status as defined by the school the *dependent* child is attending or had any other change in enrollment at such institution.

The *medically necessary leave of absence* must:

- Begin due to a *bodily injury* or *sickness*;
- Be determined *medically necessary* by the *dependent* child's *healthcare practitioner*, who must provide *us* with written certification; and
- Cause the *dependent* child to lose full-time student status as defined by the school the *dependent* child is attending.]

[SIGNATURE]

[Michael B. McCallister]
[President]

OPTIONAL MENTAL HEALTH RIDER

HUMANA INSURANCE COMPANY

[Policyholder: [John Doe]]
[Policy Number: [xxxxxxx]]
[Effective Date: [xxxxxxxxxx]]

This benefit rider is attached to and made part of the *policy* to which it is attached. Except as modified below, all *policy* terms, conditions, exclusions and limitations apply. Notwithstanding any other provisions of the *policy*, expenses covered under this rider are not covered under any other provisions of the *policy*.

Mental Health

Coverage and benefits under the *policy* for *mental disorders* are hereby deleted and replaced with the following:

Coverage will be provided for *covered expenses* incurred for *medically necessary* diagnosis and *mental health* treatment of mental illnesses. Preadmission screening and *preauthorization*, when applicable, is required to be considered *covered expenses*.

Mental health (including substance use disorders) mean those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders.

Benefits for *mental health* are payable under this rider the same as any other *sickness*. *Covered expenses* are subject to all *policy* requirements including but not limited to any *copayment, deductible, coinsurance out-of-pocket limits* and benefit and *policy* maximums.

[SIGNATURE]

[Michael B. McCallister]
[President]

HumanaOne Individual Insurance Application



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 application.

[Arkansas]

Date of application: ___/___/___ Requested Effective Date: ___/___/___

- This application is for:
- New Business (First time applicant)
 - Reinstatement (Reapplication)
 - Change/modification to existing policy

Reason for change _____

Change/Modification to Existing Policy # _____

Health & Dental Coverage Options

Health Coverage

Please complete this section when selecting a health plan.

Plan name _____

Deductible \$ _____

Dental Coverage

- Dental

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, dental is only available at your anniversary.

Optional Benefits

Please select an optional benefit if available with chosen health plan.

- Office visit copay
- Prescription drug deductible: [\$0-2,000] [\$0-2,000]
- Lifetime Maximum Buy-Up
- Supplemental Accident Benefit: [\$100-5,000] [\$100-5,000]
- Mental Disorder Benefit

Life Coverage Options

Please complete this section if choosing the term life rider or the term life plan for primary applicant and/or spouse.
 Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

Primary Applicant:

- [\$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 [\$0-1,000,000]. Additional amounts must be purchased in [\$0-100,000] increments.)

Term life insurance amount: \$ _____

Term length: [0-20] years [0-20] years [0-20] 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 [\$0-1,000,000]. Additional amounts must be purchased in [\$0-100,000] increments.)

Term life insurance amount: \$ _____

Term length: [0-20] years [0-20] years [0-20] years

Primary beneficiary name _____

Relationship _____ Benefit % _____

Contingent beneficiary name _____

Relationship _____ Benefit % _____

Primary Applicant Information

If child-only coverage is requested, the youngest child is the Primary Applicant. 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	Date of Birth / /
Home address (not P.O. Box)			City		State	ZIP code
Social Security #		Country or State of Birth		E-mail		
Type of business or industry	Occupation		Home phone # ()		Daytime phone # ()	
Mailing address (if different from home address)			City		State	ZIP code
Policyholder name if different than Primary Applicant (applicable for child-only application)						

Parent or Guardian Information

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

First name	MI	Last name	E-mail		
Home address (not P.O. 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 applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
Country or State of Birth	Spouse's type of business or industry		Spouse's occupation			
Social Security #			E-mail			

Dependent 1 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]			[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Dependent 2 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]			[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Dependent 3 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]			[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Dependent 4 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-18] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]			[Residential address different than primary applicant? <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 applying for health coverage, please provide the status of current coverage, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

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

[• **If yes, please supply the following for all applicants on the policy:**

Name(s) of covered persons _____

Insurance Carrier Name _____

Effective Date ___/___/_____

• Existing Dental Coverage

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

[• **If yes, please supply the following for all applicants on the policy:**

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 applied for be used to replace existing dental coverage?]

• Existing Life Coverage

Primary Applicant:

- [1. No Yes Do you have any life insurance and/or annuity coverage currently in force?]
- [2. No Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?]

[• **If yes, please supply the following information:**

Company name	Amount \$	Policy #]
--------------	-----------	----------	---

Spouse:

- [1. No Yes Do you have any life insurance and/or annuity coverage currently in force?]
- [2. No Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?]

[• **If yes, please supply the following information:**

Company name	Amount \$	Policy #]
--------------	-----------	----------	---

Eligibility & Health Status

Please answer for all individuals applying 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 applying for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to disclose any health information may result in your policy being modified or terminated, back to your original effective date.

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

[• **If yes:** Name(s): _____]

[Has anyone applying 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 applicant or spouse applying for coverage used any tobacco product?]
[Primary Applicant: No Yes]
[Spouse: No Yes]
[Dependent: No Yes]
- [4. No Yes Does anyone applying for coverage plan to participate in any dangerous or extreme sport activities?]
- [5. No Yes Is the primary applicant, spouse or any of their dependents pregnant or an expectant mother or father?]

[Within the past [1-5] years, has anyone applying 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 applying 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 applying 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 applying 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 applying 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 applying 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 applying 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 applicant or legal representative and/or spouse (if applying).

[Question #	Letter	Person treated	Condition
Details:]

[Question #	Letter	Person treated	Condition
Details:]

[Question #	Letter	Person treated	Condition
Details:]

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 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 policy applied 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 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. Unless Humana agrees to an earlier date, coverage for sickness begins on the 15th day after a person becomes insured for injury. I understand that my policy may be issued with a condition specific deductible for a specified pre-existing health condition whether or not the condition was disclosed on the 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. By signing below, I agree to terminate existing coverage if approved. [As a parent or legal guardian of a dependent [under the age of] [0-18] years [or older] applying 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 application.]

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

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 Applicant or Legal Guardian Signature _____ Date ____/____/____

Relationship of Legal Guardian _____

Spouse Signature _____ Date ____/____/____
(if covered dependent)

[Dependent Signature [(if over [0-40])] [(if [0-40] and older)] [(if you are between the ages of [0-40] and [0-40])] _____ Date ____/____/____]

[Dependent Signature [(if over [0-40])] [(if [0-40] and older)] [(if you are between the ages of [0-40] and [0-40])] _____ Date ____/____/____]

Agent / Producer Information

This section to be completed by Agent or Producer.

[1. Agent / Agency of Record: [(for commissions and correspondence)]	[2. Agent / Agency of Record: [(for split-commissions)]
Name (print) _____	Name (print) _____
Humana Agent # _____	Humana Agent # _____
[Commission split: <input type="checkbox"/> No <input type="checkbox"/> Yes	[Percentage of sales: <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, percentage _____ (Total should equal 100%)]	If yes, percentage _____ (Total should equal 100%)]
[1. Writing Agent / Producer:	[2. Writing Agent / Producer: (for split-commissions)
Name (print) _____	Name (print) _____
Humana Agent # _____	Humana Agent # _____
[Commission split: <input type="checkbox"/> No <input type="checkbox"/> Yes	[Percentage of sales: <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, percentage _____ (Total should equal 100%)]	If yes, percentage _____ (Total should equal 100%)]

Agent replacement question:

[Will this policy 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 applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Writing Agent's Signature _____ Date ____/____/____

[The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.]

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]**



SERFF Tracking Number: HUMA-126299751

State: Arkansas

Filing Company: Humana Insurance Company

State Tracking Number: 43574

Company Tracking Number:

TOI: H16I Individual Health - Major Medical

Sub-TOI: H16I.005A Individual - Preferred Provider
(PPO)

Product Name: AR MAINT 7/2009

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/28/2009
Comments:	Please see attached		
Attachment:	IMM Certificate of Readability.pdf		
Bypassed - Item:	Application	Approved-Closed	09/28/2009
Bypass Reason:	NA		
Comments:			
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/28/2009
Bypass Reason:	NA - No changes being made that affect Outline		
Comments:			
Satisfied - Item:	NAIC Transmittal	Approved-Closed	09/28/2009
Comments:	Please see attached		
Attachment:	IMM Signed Transmittal.pdf		
Satisfied - Item:	Cover Letter	Approved-Closed	09/28/2009

SERFF Tracking Number: HUMA-126299751 *State:* Arkansas
Filing Company: Humana Insurance Company *State Tracking Number:* 43574
Company Tracking Number:
TOI: H161 Individual Health - Major Medical *Sub-TOI:* H161.005A Individual - Preferred Provider
(PPO)
Product Name: AR MAINT 7/2009
Project Name/Number: /

Comments:

Please see attached

Attachment:

IMM Cover letter.pdf

CERTIFICATION

RE: AR-70129 MAINT 7/2009

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-70129 MAINT 8/2009

Flesch Test Reading Ease Score

41.6



Signed by: _____

Steve DeRaleau
Vice President

Date: September 9, 2009

Reset Form

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
-----------	----------------------------------	----------

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Humana Insurance Company 1100 Employers Blvd Green Bay WI 54344	WI		119	73288	39-1263473	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Berthena Reed N19 24133 Riverwood Dr Ste 250 Waukesha WI 53188	800-289-0260 Ext 2516	920-339-7004	breed2@humana.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
-----------	------------------------------	--

6.	Company Tracking Number	AR-MAINT 7/2009
-----------	--------------------------------	-----------------

7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
-----------	--	-----------------------

8.	Market	<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: _____
-----------	---------------	---

9.	Type of Insurance	H16I Individual Health-Major Medical
-----------	--------------------------	--------------------------------------

10.	Product Coding Matrix Filing Code	H16L.005A Individual-Preferred Provider(PPO)
------------	--	--

11.	Submitted Documents	<p>FORMS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Policy</td> <td><input type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input type="checkbox"/> Application/Enrollment</td> <td><input checked="" type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input type="checkbox"/> Application/Enrollment	<input checked="" type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other		
<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate										
<input type="checkbox"/> Application/Enrollment	<input checked="" type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising										
<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other											
		<p><input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____</p> <p>SUPPORTING DOCUMENTATION</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input checked="" type="checkbox"/> Statement of Variability</td> <td><input checked="" type="checkbox"/> Certifications</td> </tr> <tr> <td><input type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<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 _____	
<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 _____												

12.	Filing Submission Date	09/11/2009	
13.	Filing Fee (If required)	Amount	\$50
		Check Date	EFT
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval		
15.	Filing Description:		
		See attached cover letter	
		<div style="border: 1px solid black; padding: 5px; display: inline-block;">View Complete Filing Description</div>	

16.	Certification (If required)
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>	
Print Name	<u>Berthena Reed</u> Title <u>Compliance Analyst</u>
Signature	<u></u> Date: <u>9-11-2009</u>

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		AR-MAINT 7/2009
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Arkansas Maintenance Rider	AR-70129 MAINT 8/2009	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Optional Mental Health Rider	AR-70129 8/2002 MENTAL	<input checked="" 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 _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	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 _____	

LH RFA-1

September 9, 2009

Life and Health Division
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: HUMANA INSURANCE COMPANY
Individual Health Form Filing
Arkansas Rider: AR-70129 MAINT 8/2009
NAIC #73288
FEIN #39-1263473

Dear Sir/Madam:

We are enclosing the above-referenced form for your review and approval. This form is new and will not replace any previously filed or approved forms.

Form AR-70129 MAINT 8/2009 will be used with our Individual Health policy series, Form GN-70129 8/2002, et al, which was approved by your Department on May 24, 2005. This rider is being filed to comply with the Federal H.R. 2851, "Michelle's Law", which allows seriously ill college students, who are covered dependents under health plans, to remain covered for up to one year while on a medically necessary leave of absence. We have also added an optional Mental Health Rider which is being made available to members to comply with Arkansas HB 2195.

The language in the rider may be incorporated into the body of the policy when issued.

If you have any questions regarding this submission, you may contact me by telephone at 1-800-289-0260 extension 2516, by fax at 920-339-7004 or by email at breed2@humana.com.

Sincerely,
HUMANA INSURANCE COMPANY

Berthena Reed
Contract Analyst