

SERFF Tracking Number: HUMA-126349591 State: Arkansas
Filing Company: American Dental Providers of Arkansas, Inc. State Tracking Number: 43833
Company Tracking Number: CBIC INDV. VISION APPL. 2009
TOI: H20I Individual Health - Vision Sub-TOI: H20I.000 Health - Vision
Product Name: AR CBIC INDV. Vision Appl. 2009
Project Name/Number: CBIC INDV. Vision Appl. 2009/CBIC INDV. Vision Appl. 2009

Filing at a Glance

Company: American Dental Providers of Arkansas, Inc.

Product Name: AR CBIC INDV. Vision Appl. 2009 SERFF Tr Num: HUMA-126349591 State: Arkansas

TOI: H20I Individual Health - Vision SERFF Status: Closed-Approved- Closed State Tr Num: 43833

Sub-TOI: H20I.000 Health - Vision Co Tr Num: CBIC INDV. VISION APPL. 2009 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor
Disposition Date: 10/29/2009
Authors: Erin Hermsen, Paula Konop, Antoine Stewart, John Goodwin, Tina Huettl, Christi Conrad

Date Submitted: 10/22/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: CBIC INDV. Vision Appl. 2009
Project Number: CBIC INDV. Vision Appl. 2009
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/29/2009

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: 10/29/2009
Created By: John Goodwin
Corresponding Filing Tracking Number: CBIC INDV. Vision Appl. 2009

Deemer Date:

Submitted By: John Goodwin

Filing Description:

CompBenefits Insurance Company

NAIC#: 60984

FEIN#: 74-2552026

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RE: Form: Form Number:
Application AR-72005 10/2009

To Whom It May Concern:

Please find the above referenced form for the Department's approval. Upon approval CompBenefits Insurance Company, a subsidiary of the Humana, Inc. family of companies, will use this application with individual vision product Form, Individual Vision Policy, Form Number: VIND-POLICY.001 (AR) approved by the Department on March 09, 2005. The above referenced form is new and not intended to replace any previously filed and approved form.

Thank you for your assistance with this filing. Should you require additional information or have any questions please call me at 770.998.8936, ext. 88065.

John Goodwin
Analyst
Humana Specialty Benefits

Company and Contact

Filing Contact Information

John Goodwin, Senior Compliance Analyst jgoodwin@compbenefits.com
100 Mansell Court E. 770-998-8936 [Phone] 88065 [Ext]
Suite 400
Roswell, GA 30076

Filing Company Information

American Dental Providers of Arkansas, Inc. CoCode: 11559 State of Domicile: Arkansas
The Corporation Company Group Code: 119 Company Type:
425 W. Capitol Ave. Group Name: State ID Number:
Suite 1700 FEIN Number: 58-2302163
Little Rock, AR 72201
(305) 262-1333 ext. [Phone]

Filing Fees

SERFF Tracking Number: HUMA-126349591 State: Arkansas
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Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: Application filing fee.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Dental Providers of Arkansas, Inc.	\$20.00	10/22/2009	31472147

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/29/2009	10/29/2009

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Disposition

Disposition Date: 10/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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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	Statement of Variability-Application	Approved-Closed	Yes
Form	HumanaOne Vision Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AR-72005 10/2009

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 10/29/2009	AR-72005 10/2009	Application/HumanaOne Vision Enrollment Application Form	Initial			AR-72005- 1009.pdf

HumanaOne [Dental] [&] [Vision] Application



Requested Effective Date: ___/___/___

This application is for: New Business (First time applicant) Reinstatement (Reapplication)
 Change/Modification to Existing Policy or Plan

[Arkansas]

[Reason for change _____] [Change/Modification to Existing Policy or Plan # _____]

[1-6.] Coverage Options Please complete this section when selecting a [dental] [or] [vision] product.

[Dental Coverage] [Plan name] [Vision Coverage] [Plan name]

[1-6.] 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	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/
Home address (not P.O. Box)			City	State	ZIP code	
E-mail		Home phone # ()	Daytime phone # ()			
Social Security #		Dentist name			Facility #	

[1-6.] Parent or Guardian Information Please complete this section if Primary Applicant is under [0-40] 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)		

[1-6.] 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	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/
Social Security #	E-mail		Dentist name		Facility #	

Dependent First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/
Social Security #	E-mail		Dentist name		Facility #	

Dependent First name	MI	Last name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth	/	/
Social Security #	E-mail		Dentist name		Facility #	

[1-6.] 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 agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. [I have received and reviewed any state or federal required disclosures.] I acknowledge that neither I nor the agent have the right to waive or incompletely answer 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 will not use pre-tax income to pay premiums associated with this policy or otherwise 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. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the HumanaOne Payment & Billing Authorization form. 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. [As a parent or legal guardian of a dependent [under the age of] [0-40] years [or older] applying for coverage, I attest by my signature below, that I have gathered the necessary health information regarding my dependent in order to fully and truthfully complete this application.] [A minimum [0-2] year contract is required for vision plans.] [A minimum [0-2] year contract is required for dental plans.] 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 an insurance product or to give you insurance benefits. Do not cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

Primary Applicant or Legal Guardian Signature _____ Date ___/___/___

Relationship of Legal Guardian _____

Spouse Signature (if covered dependent) _____ 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 ___/___/___

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 Signature on page [2]]

[1-6.] 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%)]	

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 product 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 product 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."
[Dental product [insured] or [administered] by American Dental Providers of Arkansas, Inc.]
[Vision product offered by CompBenefits Insurance Company]

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	10/29/2009
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/29/2009
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/29/2009
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability-Application	Approved-Closed	10/29/2009
Comments:			
Attachment:			
Statement of Variability Appl.Document.pdf			



Statement of Variability

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

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