

SERFF Tracking Number: HUMA-126378962 State: Arkansas  
Filing Company: Humana Insurance Company State Tracking Number: 44025  
Company Tracking Number:  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
Product Name: AR-71002 11/2009  
Project Name/Number: /

## Filing at a Glance

Company: Humana Insurance Company  
Product Name: AR-71002 11/2009  
TOI: H16I Individual Health - Major Medical  
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
Filing Type: Form

SERFF Tr Num: HUMA-126378962 State: Arkansas  
SERFF Status: Closed-Approved- Closed State Tr Num: 44025  
Co Tr Num: State Status: Approved-Closed  
Reviewer(s): Rosalind Minor  
Author: Latunia Riley Disposition Date: 11/13/2009  
Date Submitted: 11/10/2009 Disposition Status: Approved-Closed  
Implementation Date:

Implementation Date Requested:  
State Filing Description:

## General Information

Project Name:  
Project Number:  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 11/13/2009

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: 11/13/2009  
Created By: Latunia Riley  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Latunia Riley  
Filing Description:  
Revised Application filing

## Company and Contact

### Filing Contact Information

Latunia Riley, Contract Analyst  
2 Riverwood Place

lriley2@humana.com  
262-951-2617 [Phone]

SERFF Tracking Number: HUMA-126378962 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 44025  
 Company Tracking Number:  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider  
 (PPO)

Product Name: AR-71002 11/2009  
 Project Name/Number: /

W24133 Riverwood Dr.  
 Suite 250  
 Waukesha, WI 53188

**Filing Company Information**

Humana Insurance Company  
 1100 Employers Boulevard  
 Green Bay, WI 54344  
 (800) 558-4444 ext. [Phone]

CoCode: 73288  
 Group Code: 119  
 Group Name:  
 FEIN Number: 39-1263473

State of Domicile: Wisconsin  
 Company Type: Life & Health  
 State ID Number:

-----

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$25.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$25.00	11/10/2009	31944135

SERFF Tracking Number: HUMA-126378962 State: Arkansas  
Filing Company: Humana Insurance Company State Tracking Number: 44025  
Company Tracking Number:  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
Product Name: AR-71002 11/2009  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/13/2009	11/13/2009

SERFF Tracking Number: HUMA-126378962 State: Arkansas  
Filing Company: Humana Insurance Company State Tracking Number: 44025  
Company Tracking Number:  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider  
(PPO)  
Product Name: AR-71002 11/2009  
Project Name/Number: /

## Disposition

Disposition Date: 11/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.



SERFF Tracking Number: HUMA-126378962 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 44025  
 Company Tracking Number:  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: AR-71002 11/2009  
 Project Name/Number: /

## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/13/2009	AR-71002	Certificate	Humana One Individual Insurance Application	Initial		49.600	AR-71002-1109.pdf

# 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.

<b>Spouse</b> 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			

<b>Dependent 1</b> 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]			

<b>Dependent 2</b> 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]			

<b>Dependent 3</b> 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]			

<b>Dependent 4</b> 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. 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.**

<b>[1. Agent / Agency of Record: [(for commissions and correspondence)]</b>	<b>[2. Agent / Agency of Record: [(for split-commissions)]</b>
Name (print) Humana Agent # [Commission split: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage (Total should equal 100%) ]	Name (print) Humana Agent # [Percentage of sales: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage (Total should equal 100%) ]
<b>[1. Writing Agent / Producer:</b>	<b>[2. Writing Agent / Producer: (for split-commissions)</b>
Name (print) Humana Agent # [Commission split: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage (Total should equal 100%) ]	Name (print) Humana Agent # [Percentage of sales: <input type="checkbox"/> No <input type="checkbox"/> Yes 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-126378962 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 44025  
 Company Tracking Number:  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: AR-71002 11/2009  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/13/2009
<b>Comments:</b>		
<b>Attachment:</b> Certificate of Readability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	11/13/2009
<b>Bypass Reason:</b> Revised application attached to form tab		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	11/13/2009
<b>Bypass Reason:</b> Not Applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	11/13/2009
<b>Bypass Reason:</b> Not Applicable		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter	Approved-Closed	11/13/2009
<b>Comments:</b>		
<b>Attachment:</b> Signed Cover Letter.pdf		

SERFF Tracking Number: HUMA-126378962 State: Arkansas  
Filing Company: Humana Insurance Company State Tracking Number: 44025  
Company Tracking Number:  
TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider  
(PPO)  
Product Name: AR-71002 11/2009  
Project Name/Number: /

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability	Approved-Closed	11/13/2009
<b>Comments:</b>		
<b>Attachment:</b> Statement of Variability.Application.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Signed NAIC Transmittal Document	Approved-Closed	11/13/2009
<b>Comments:</b>		
<b>Attachment:</b> AR Signed Transmittal Document.pdf		

## CERTIFICATION

**RE: AR-71002 11/2009**

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- 71002 11/2009

**Flesch Test Reading Ease Score**

49.6



**Signed by:** \_\_\_\_\_

Steve DeRaleau  
Vice President

**Date:** November 10, 2009

November 10, 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 Application: AR-71002 11/2009  
NAIC #73288  
FEIN #39-1263473**

**Via Electronic Submission (SERFF) - HUMA # 126378962**

Dear Sir/Madam:

We are enclosing the above-referenced for your review and approval. This application replaces AR-71002 9/2009 that was originally approved by your department on 10/1/2009 under HUMA-12699751. The revised application will remain the same, except the following has been removed in its entirety due to language error on our Humana Insurance Company behalf.

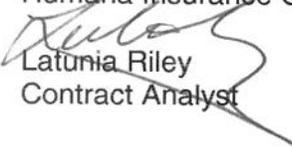
" Unless Humana agrees to an earlier date, coverage for sickness begins on the 15th day after a person becomes insured for injury. I understand that my policy may be issued with a condition specific deductible for a specified pre-existing health condition whether or not the condition was disclosed on the application."

Included with this submission are:

- Readability Certification;
- NAIC Transmittal Document; and
- Statement of Variability.

If you have any questions regarding this filing, please contact me by phone at 1-800-289-0260, extension 2617, by fax at 920-632-0029 or by e-mail at lriley2@humana.com.

Sincerely,  
Humana Insurance Company

  
Latunia Riley  
Contract Analyst

## **Statement of Variability for Application 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.

Reset Form

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

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
-----------	----------------------------------	----------

<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 Insurance Company N19 W24133 Riverwood Drive Ste 250 Waukesha, WI 53188	Wisconsin	Life, Accident & Health	119	73288	391263473	

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

<b>5.</b>	<b>Requested Filing Mode</b>	<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): _____
-----------	------------------------------	--

<b>6.</b>	<b>Company Tracking Number</b>	AR-71002 11/2009
-----------	--------------------------------	------------------

<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: _____
-----------	---------------	---

<b>9.</b>	<b>Type of Insurance</b>	H16I Individual Health-Major Medical
-----------	--------------------------	--------------------------------------

<b>10.</b>	<b>Product Coding Matrix Filing Code</b>	H16I.005A Individual-Preferred Provider(PPO)
------------	--	--

<b>11.</b>	<b>Submitted Documents</b>	<p><b><input checked="" type="checkbox"/> FORMS</b></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 checked="" type="checkbox"/> Application/Enrollment</td> <td><input 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><b><u>Rates</u></b></p> <p><input type="checkbox"/> New Rate      <input type="checkbox"/> Revised Rate</p> <p><input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____</p> <p><b><u>SUPPORTING DOCUMENTATION</u></b></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"/> Policy	<input type="checkbox"/> Outline of Coverage	<input 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		<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"/> Policy	<input type="checkbox"/> Outline of Coverage	<input 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																				
<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 _____																					



17.	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>	AR-71002 11/2009	
<b>This filing corresponds to rate filing company tracking number</b>	N/A	

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Humana One Individual Insurance Application Application	AR-71002 11/2009	<input type="checkbox"/> Initial <input checked="" type="checkbox"/> Revised <input type="checkbox"/> Other _____	AR-71002 9/2009
02			<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		AR-71002 11/2009		
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 _____	

LH RFA-1