

SERFF Tracking Number:	ICCI-126206699	State:	Arkansas
Filing Company:	HumanaDental Insurance Company	State Tracking Number:	42769
Company Tracking Number:	72002-0709		
TOI:	H10G Group Health - Dental	Sub-TOI:	H10G.000 Health - Dental
Product Name:	Humana rev App 72002 (7-09)		
Project Name/Number:	Humana rev App 72002 (7-09)/Humana rev App 72002 (7-09)		

Filing at a Glance

Company: HumanaDental Insurance Company

Product Name: Humana rev App 72002 (7-09)	SERFF Tr Num: ICCI-126206699	State: ArkansasLH
TOI: H10G Group Health - Dental	SERFF Status: Closed	State Tr Num: 42769
Sub-TOI: H10G.000 Health - Dental	Co Tr Num: 72002-0709	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Brenda Dawson	Disposition Date: 06/29/2009
	Date Submitted: 06/26/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Humana rev App 72002 (7-09)	Status of Filing in Domicile:
Project Number: Humana rev App 72002 (7-09)	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: Resubmission	Previous Filing Number: 42373
Group Market Size:	Overall Rate Impact:
Group Market Type:	Filing Status Changed: 06/29/2009
Explanation for Other Group Market Type:	
State Status Changed: 06/29/2009	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	

On May 20, 2009 the Department approved under SERFF Tracking # ICCI-126056991 and State Tracking # 42373 application form AR-72002 3/2009. We are respectfully requesting the Department replace that application with Enrollment Form AR-72002 7/2009 attached to the Form Schedule tab.

Insurance Compliance Consultants, Inc., has been authorized by HumanaDental Insurance Company to make this filing. An authorization letter has been included in the Supporting Documentation tab.

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<i>Company Tracking Number:</i>	<i>72002-0709</i>		
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<i>Product Name:</i>	<i>Humana rev App 72002 (7-09)</i>		
<i>Project Name/Number:</i>	<i>Humana rev App 72002 (7-09)/Humana rev App 72002 (7-09)</i>		

The revisions in Enrollment Form AR-72002 7/2009 consist of the following:

1. The heading of this Enrollment form states "Enrollment Form" whereas the prior application stated "Application".
2. The form number on the bottom left hand corner was changed to 7/2009.
3. Under Section 5 references to "primary applicant" were changed to "primary insured".
4. On page 2 under Agreement and Signature, the words "plan" and "certificate" were replaced with the word "policy", "enrollment form" was replaced with the word "application", and the last 4 sentences in the first paragraph pertaining to "Membership in the Association" have been added.
5. Also on page 2, just underneath the signature box, a bracketed sentence stating [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.]

Your acknowledgement of replacement of this application is greatly appreciated. If you have any questions please feel free to call me at (815) 316-6714 or email me at Brendadawson@inscompliance.com.

Company and Contact

Filing Contact Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Brenda Dawson, Authorized Representative	Brendadawson@inscompliance.com
3925 East State Street, Suite 200	(815) 316-6714 [Phone]
Rockford, IL 61108	(815) 986-2355[FAX]

Filing Company Information

HumanaDental Insurance Company	CoCode: 70580	State of Domicile: Wisconsin
P. O. Box 740036	Group Code: 119	Company Type: Life & Health
Louisville, KY 40201-7436	Group Name: HumanaDental	State ID Number:
(800) 233-4013 ext. [Phone]	FEIN Number: 39-0714280	

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HumanaDental Insurance Company	\$20.00	06/26/2009	28829852

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/29/2009	06/29/2009

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Disposition

Disposition Date: 06/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	HumanaDental Authorization Letter	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: ICCL-126206699 State: Arkansas
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Form Schedule

Lead Form Number: 72002-0709

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR-72002 7/2009	Application/ Enrollment Form Enrollment Form	Revised	Replaced Form #: AR-72002 3/2009 Previous Filing #: 42373		AR-72002-0709-FS 6-25-09.pdf

HumanaOne Dental & Vision Enrollment Form

HUMANA
one

Requested Effective Date: ___/___/___

This form is for: New Business (First time enrollee) Reinstatement (Reenrollment)
 Change/Modification to Existing Policy or Plan

Arkansas

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

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

<input type="checkbox"/> Dental Coverage		<input type="checkbox"/> Vision Coverage	
Product Name	[Facility #]	Product Name	

[2.] Primary Insured Information

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

First name	MI	Last name	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]		[Humana Medicare Member ID/HICN]			

[3.] Parent or Guardian Information Please complete this section if Primary Insured 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)

[4.] Family Information

Please complete only if your spouse and/or dependent children are enrolling 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 #	[Humana Medicare Member ID/HICN]		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 #	[Humana Medicare Member ID/HICN]		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 #	[Humana Medicare Member ID/HICN]		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 #	[Humana Medicare Member ID/HICN]		E-mail			
[Dentist Name]		[Facility #]				

[5.] Agent / Producer Information This section to be completed by Agent or Producer.

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

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary insured submitting this enrollment form 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 insured in the benefit summary document or other product literature.

Writing agent's signature _____ [Date ___/___/___]

[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 have received and reviewed any state or federal required disclosures. Neither I nor any agent or producer 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 product applied for is not an employer-sponsored group insurance 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 insurance plan or receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this enrollment form for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate. Acceptance of premium and fees does not guarantee coverage. I agree to automatic withdrawal from my specified bank account or credit card for premium payment and administrative fees if selected on the HumanaOne Dental & Vision Payment & Billing Authorization form. Any misrepresentation on this enrollment form may be used by Humana during the first [0-2] certificate 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 [0-18] years or older enrolling for coverage, I attest by my signature below, that I have gathered the necessary insurance information from my dependent in order to fully and truthfully complete this enrollment form. This document, together with any supplements, will form part of and be the basis for any certificate issued. Membership in the Association is required, at an additional cost, in order to be eligible for insurance coverage. The Association is a membership organization that provides educational information and discounts on goods and services to its members. The Association benefits information will be sent under separate cover. I understand while covered by this product that I must at all times be a member of the Association.

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.

Primary Insured or Legal Guardian Signature _____ [Date ____/____/____]

Relationship of Legal Guardian _____

Spouse Signature _____ [Date ____/____/____]

(if covered dependent)

[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 enrollment form as "Humana".

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

[Vision] [products] insured by [Humana Insurance Company]

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Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	06/29/2009
Comments:		
Attachment: Cert of Comp. with Rule 19 revised enrollment form.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	06/29/2009
Comments: See Form Schedule tab.		
Satisfied -Name: HumanaDental Authorization Letter	Review Status: Approved-Closed	06/29/2009
Comments:		
Attachment: HumanaDental Authorization Letter.pdf		

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: HumanaDental Insurance Company

Form Number(s): AR-72002 7/2009

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



Signature of Company Officer

Gerald L. Ganoni

Name

President

Title

June 26, 2009

Date

HUMANA.
Guidance when you need it most

January 1, 2009

To: All State Insurance Departments

Humana Dental Insurance Company hereby authorizes Insurance Compliance Consultants, Inc., to file the attached form(s) or a state specific variation of it, and to act on Our behalf regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Humana Dental Insurance Company may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave Vanden Heuvel". The signature is fluid and cursive, with a large initial "D" and "H".

Dave Vanden Heuvel
Director of Business Services
HumanaDental, Inc.