

| | | | |
|--------------------------|---|------------------------|--------------------------|
| SERFF Tracking Number: | ICCI-126206773 | State: | Arkansas |
| Filing Company: | Humana Insurance Company | State Tracking Number: | 42763 |
| Company Tracking Number: | 72002-0709 | | |
| TOI: | H20G Group Health - Vision | Sub-TOI: | H20G.000 Health - Vision |
| Product Name: | Humana rev App 72002-0709 | | |
| Project Name/Number: | Humana rev App 72002-0709/Humana rev App 72002-0709 | | |

Filing at a Glance

Company: Humana Insurance Company

Product Name: Humana rev App 72002-0709

TOI: H20G Group Health - Vision

Sub-TOI: H20G.000 Health - Vision

Filing Type: Form

SERFF Tr Num: ICCI-126206773

SERFF Status: Closed

Co Tr Num: 72002-0709

Co Status:

Author: Brenda Dawson

Date Submitted: 06/26/2009

State: ArkansasLH

State Tr Num: 42763

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 06/26/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Humana rev App 72002-0709

Project Number: Humana rev App 72002-0709

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: Resubmission

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/26/2009

Corresponding Filing Tracking Number:

Filing Description:

On May 27, 2009 the Department approved under SERFF Tracking # ICCI-126062011 and State Tracking # 42360 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.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Previous Filing Number: 42360

Overall Rate Impact:

Filing Status Changed: 06/26/2009

Deemer Date:

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

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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

Humana Insurance Company CoCode: 73288 State of Domicile: Wisconsin
P.O Box 740036 Group Code: 119 Company Type: L&H
500 West Main Street
Louisville, KY 40201-7436 Group Name: Humana Insurance State ID Number:
Company
(502) 580-2712 ext. [Phone] FEIN Number: 39-1263473

Filing Fees

SERFF Tracking Number: ICCL-126206773 State: Arkansas
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Project Name/Number: Humana rev App 72002-0709/Humana rev App 72002-0709

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

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--------------------------|---------|----------------|---------------|
| Humana Insurance Company | \$20.00 | 06/26/2009 | 28829981 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 06/26/2009 | 06/26/2009 |

SERFF Tracking Number: *ICCI-126206773* *State:* *Arkansas*
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Product Name: *Humana rev App 72002-0709*
Project Name/Number: *Humana rev App 72002-0709/Humana rev App 72002-0709*

Disposition

Disposition Date: 06/26/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ICCI-126206773 State: Arkansas
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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 | Humana Insurance Company | Approved-Closed | Yes |
| Form | Enrollment Form | Approved-Closed | Yes |

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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 | Revised | Replaced Form #: AR-72002 3/2009 Previous Filing #: 42360 | | AR-72002-0709-FS 6-25-09.pdf |

HumanaOne Dental & Vision Enrollment Form

HUMANA
one

[Arkansas]

Requested Effective Date: ___/___/___

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

[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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Rate Information

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Supporting Document Schedules

| | | |
|--|---------------------------------------|------------|
| Satisfied -Name: Flesch Certification | Review Status: Approved-Closed | 06/26/2009 |
| Comments: | | |
| Attachment: Cert of Comp. with Rule 19 revised enrollment form.pdf | | |
| Satisfied -Name: Application | Review Status: Approved-Closed | 06/26/2009 |
| Comments: See Form Schedule tab | | |
| Satisfied -Name: Humana Insurance Company | Review Status: Approved-Closed | 06/26/2009 |
| Comments: | | |
| Attachment: Humana Insurance Company 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.

March 1, 2009

To: All State Insurance Departments

Humana 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 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 'Alan Stewart', with a long horizontal line extending to the right.

Alan Stewart
Vice President
Humana Insurance Company