

SERFF Tracking Number: HUMA-126194103 State: Arkansas
Filing Company: Humana Insurance Company State Tracking Number: 42685
Company Tracking Number: AR-04-2009
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
Standard Plans
Product Name: Individual Medicare Supplement Plans
Project Name/Number: Electronic Enrollment/AR-04-2009

Filing at a Glance

Company: Humana Insurance Company

Product Name: Individual Medicare Supplement SERFF Tr Num: HUMA-126194103 State: Arkansas
Plans

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed-Filed State Tr Num: 42685
Standard Plans

Sub-TOI: MS051.001 Plan A

Co Tr Num: AR-04-2009

State Status: Filed-Closed

Filing Type: Form

Reviewer(s): Stephanie Fowler

Authors: Michele Zabel, Dennis

Disposition Date: 07/15/2009

Cowart, Paula Williamson, Adrianna
Maki

Date Submitted: 06/17/2009

Disposition Status: Filed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Electronic Enrollment

Status of Filing in Domicile: Not Filed

Project Number: AR-04-2009

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/15/2009

Explanation for Other Group Market Type:

State Status Changed: 07/15/2009

Deemer Date:

Created By: Michele Zabel

Submitted By: Michele Zabel

Corresponding Filing Tracking Number:

Filing Description:

RE: Humana Insurance Company/NAIC # 119, 73288

Medicare Supplement Electronic Enrollment Materials

Please find enclosed for your review and approval forms necessary to complete a telephonic enrollment process for Humana's Medicare Supplement insurance plans. Following is a description and form number of each piece submitted for review:

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1. T-Sig Voicelog Scripts – voicelog scripts accessed by the licensed agent to complete the telephone enrollment process.

- GH23733 (standard enrollment)
- GH23734 (applicant is replacing existing coverage)

2. GN85026EE (Enrollment Application)

An application form is populated with the applicant's responses and the completed application will be provided to the applicant when the policy is issued.

A telesales script to be utilized during this process was previously filed with and approved by your office on July 17, 2007.

If you have any questions or require additional information, I can be reach in addition to SERFF at (502) 580-8249 or by email at mzabel@humana.com.

Company and Contact

Filing Contact Information

Michele Zabel, Senior Products Compliance Analyst
 mzabel@humana.com
 500 W. Main Street
 National City Tower Offices
 29th floor
 Louisville, KY 40201

502-580-8249 [Phone]

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: \$60.00

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Retaliatory? No
Fee Explanation: \$20 per form.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$60.00	06/17/2009	28642649

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	07/15/2009	07/15/2009

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Disposition

Disposition Date: 07/15/2009

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application	Filed	Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Form	TSig Voicelog Script (Standard)	Filed	Yes
Form	TSig Voicelog Script (Replacement)	Filed	Yes
Form	Fulfillment Enrollment Application	Filed	Yes

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Form Schedule

Lead Form Number: GH23733

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed 07/15/2009	GH23733	Other	TSig Voicelog Script (Standard)	Initial			GH23733 (TSig Script).pdf
Filed 07/15/2009	GH23734	Other	TSig Voicelog Script (Replacement)	Initial			GH23734 (TSig Script).pdf
Filed 07/15/2009	GN85026E	Application/ Enrollment Form	Fulfillment Enrollment Application	Initial			GN85026EE.pdf

Medicare Supplement T-Sig Voicelog Script:

Applies to: AK, AL, AR, AZ, CO, CT, GA, HI, ID, IN, ND, NH, MD, MI, NC, NE, NV, OH, OR, RI, SC, UT, VA, and WV

Agent Calls Into Voicelog

Section 1:

Online Services Agreement:

Agreement with Humana

This agreement is between you and Humana, Inc., on behalf of its affiliates.

Consent to Electronic Transactions

I, the User, and Humana acknowledge and agree to the following provisions:

1. To conduct this enrollment and any changes made to this enrollment information through the use of an electronic transaction which will be verified by the use of an electronic signature.
2. This consent to conduct an electronic transaction only applies to enrollment services.
3. That I may request that this Agreement be terminated. If terminated, paper access to enrollment services and forms will be distributed at no cost to me if an address, phone number and a contact name are provided to a Humana representative.
4. That I may request a paper copy of this recorded transaction.
5. To be bound by this agreement as stated by law throughout the term of this Agreement.
6. This agreement may be modified at any time if Humana provides notice.

For More Information

Humana, 500 W. Main Street, Louisville, KY 40202, maintains this Humana digital recording.

End of Section 1 – Agent confirms acceptance, **“Do you understand the statements as they have been read”**

You will receive full details on Humana’s privacy policies as well as several important disclosure agreements by mail. We encourage you to take the time to review them in detail once you receive them. In order to complete your enrollment now, however, I will need to review the highlights of these statements with you and will be asking you for your agreement at the conclusion.

Section 2:

Do you understand that by completing this enrollment application you agree to the following:

- You have the right to appeal plan decisions about payments and services.
- You acknowledge that Humana will release your information to Medicare and other plans as necessary for treatment, payment and healthcare operations.
- You understand that the information you have given us is correct to the best of your knowledge.
- If you are completing this enrollment process on behalf of someone else, you attest that you are authorized under the state law and have documentation of this authority.
- Humana is not liable for bills incurred before the effective date of coverage.
- You understand that if your application is not submitted during an Open Enrollment or guaranteed issue period, Humana has the right to reject your application and any premiums paid will be refunded. You also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an Open Enrollment or guaranteed issue period or satisfy the creditable coverage requirements.
- This is a Medicare Supplement (also know as Medigap) plan and you will need to keep Medicare parts A and B, and you can only be in one Medicare Supplement plan at a time.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

End of Section 2 – Agent confirms acceptance, *“Do you understand the statements as they have been read”*

End of interaction with Voicelog

Blue text = read by recording Red text = read by agent Black text = not read

Medicare Supplement T-Sig Voicelog Script:

Applicant is Replacing Existing Coverage

Applies to: AK, AL, AR, AZ, CO, CT, GA, HI, ID, IN, ND, NH, MD, MI, NC, NE, NV, OH, OR, RI, SC, UT, VA, and WV

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You will receive full details on Humana’s privacy policies as well as several important disclosure agreements by mail. We encourage you to take the time to review them in detail once you receive them. In order to complete your enrollment now, however, I will need to review the highlights of these statements with you and will be asking you for your agreement at the conclusion.

Section 2:

Do you understand that by completing this enrollment application you agree to the following:

- According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by Humana Insurance Company. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy
- You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.
- Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- If you still wish to terminate your present policy/certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy/certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
- Do not cancel your present policy/certificate until you have received your new policy/certificate and are sure that you want to keep it.
- You have the right to appeal plan decisions about payments and services.
- You acknowledge that Humana will release your information to Medicare and other plans as necessary for treatment, payment and healthcare operations.
- You understand that the information you have given us is correct to the best of your knowledge.

- If you are completing this enrollment process on behalf of someone else, you attest that you are authorized under the state law and have documentation of this authority.
- Humana is not liable for bills incurred before the effective date of coverage.
- You understand that if your application is not submitted during an Open Enrollment or guaranteed issue period, Humana has the right to reject your application and any premiums paid will be refunded. You also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an Open Enrollment or guaranteed issue period or satisfy the creditable coverage requirements.
- This is a Medicare Supplement (also know as Medigap) plan and you will need to keep Medicare parts A and B, and you can only be in one Medicare Supplement plan at a time.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

End of Section 2 – Agent confirms acceptance, *“Do you understand the statements as they have been read”*

End of interaction with Voicelog

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MEDICARE SUPPLEMENT ENROLLMENT APPLICATION

Please review the following copy of your application. If any of the information contained in your application, including that which is related to your medical history (when applying outside of guaranteed issue periods), is incorrect or incomplete, please contact Humana within 10 days by calling [1-800-866-0581]. If you are speech or hearing impaired and use a TTY, please call [1-800-833-3301]. You can also contact us by mail at Humana, [P.O. Box 70329, Louisville, KY 40202]. Depending upon the circumstances of your enrollment, you may not have been asked all of the questions contained in this application. Questions which you were not required to answer appear blank or do not display a Yes or No response.

This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information provided are correct and complete.

SECTION 1 – PERSONAL INFORMATION

SOCIAL SECURITY NUMBER: ___ / ___ / ___

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ STATE: __ ZIP CODE: _____ COUNTY: _____

PHONE: (___) ___ - _____ DATE OF BIRTH: ___ / ___ / ___ GENDER: M F

MAILING ADDRESS (Only if different from Street Address):

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ STATE: __ ZIP CODE: _____

E-MAIL ADDRESS: _____

(E-mail address, if available, will be used as a means to communicate only Humana information.)

In which Humana Medicare Supplement plan do you wish to enroll?

- Plan A
- Plan B
- Plan C
- Plan F
- High Deductible Plan F
- Plan K
- Plan L

PROPOSED EFFECTIVE DATE:

___ / ___ / ___

Please complete the information below as it appears on your Medicare card.

MEDICARE CLAIM NUMBER _____

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) ___ / ___ / ___

MEDICAL INSURANCE (PART B) ___ / ___ / ___

Person to Notify in an Emergency (nearest relative or friend):

LAST NAME: _____ FIRST NAME: _____

MIDDLE INITIAL: _ RELATIONSHIP TO APPLICANT: _____ PHONE: (___) ___ - _____

GN85026EE

SECTION 2 – OTHER COVERAGE INFORMATION

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

YES OR NO ANSWERS WILL BE REQUIRED TO THE FOLLOWING QUESTIONS. PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Did you turn age 65 in the last six months? Yes No

2. Did you enroll in Medicare Part B in the last six months? Yes No

If yes, what is the effective date? ___/___/___

3. Are you covered for medical assistance through the State Medicaid program? Yes No

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No

b. Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium?
 Yes No

4. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END ___/___/___

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No N/A no longer covered

b. Was this your first time in this type of Medicare plan? Yes No

c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

5. Do you have another Medicare supplement policy in force? Yes No

a. If so, with what company? _____

What plan do you have? _____

b. If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes No

a. If so, with what company? _____

What plan do you have? _____

b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)

START ___/___/___ END ___/___/___

SECTION 3 – GUARANTEED ACCEPTANCE DETERMINATION

PLEASE ANSWER THE FOLLOWING QUESTIONS TO DETERMINE IF YOU ARE ELIGIBLE FOR GUARANTEED ACCEPTANCE, TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medigap Open Enrollment period? Yes No
If yes, you qualify for the Preferred rates.
2. Have you lost other health coverage which would qualify you for guaranteed acceptance? (NOTE: To be considered for guaranteed acceptance, Humana must receive your application, along with a copy of the termination notice you received from your prior insurer, within 63 days of termination of your prior coverage.) Yes No
If yes, you qualify for the Preferred rates.

SECTION 4 – MEDICAL QUESTIONS

YES OR NO ANSWERS WILL BE REQUIRED TO THE FOLLOWING QUESTIONS, TO THE BEST OF YOUR KNOWLEDGE UNLESS YOU INDICATED THAT YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDIGAP OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE.

1. In the last year, have you been hospitalized, confined to a nursing facility; or are you bedridden or confined to a wheelchair? Yes No
2. In the past 90 days have you received Home Health care? Yes No
3. Do you now have or within the last two years have you had or been advised by a physician that you need treatment or surgery for:
 - a. Heart, Coronary or Carotid Artery Disease (not including high blood pressure); Peripheral Vascular Disease; Congestive Heart Failure or any other type of Heart Failure; Enlarged Heart; Stroke; Transient Ischemic Attacks (TIA); or Heart Rhythm Disorders? Yes No
 - b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year? Yes No
 - c. Parkinson's Disease; Multiple or Lateral Sclerosis; Huntington's Disease; Muscular Dystrophy; Lupus; Hepatitis; or Lou Gehrig Disease? Yes No
 - d. Alzheimer's Disease, senile dementia, organic brain disorders, senility disorder, schizophrenia; other major depressive disorders; mental or nervous disorders; cirrhosis, alcoholism or drug abuse? Yes No
 - e. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection? Yes No
 - f. Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily? Yes No
 - g. Internal cancer, leukemia or melanoma? Yes No
 - h. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? Yes No
 - i. Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations; spinal cord disorders/injuries? Yes No
 - j. Organ transplantation? Yes No

SECTION 5 - MONTHLY PREMIUM DETERMINATION

YOU MUST ANSWER THESE QUESTIONS TO DETERMINE YOUR MONTHLY PREMIUM UNLESS YOU INDICATED THAT YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDIGAP OPEN ENROLLMENT PERIOD, OR QUALIFY FOR GUARANTEED ACCEPTANCE.

Did you have Medicare coverage prior to age 65? Yes No

Have you used tobacco products within the last 12 months? Yes No

If your application is accepted, and you answered No to both questions, you qualify for the Preferred rates.

SECTION 6 - PAYMENT OPTIONS

PREMIUM PAYMENT INFORMATION HAS BEEN INTENTIONALLY REMOVED FROM THIS COPY OF YOUR COMPLETED ENROLLMENT APPLICATION IN ORDER TO SAFEGUARD YOUR PERSONAL FINANCIAL INFORMATION.

I understand that if my application is not submitted during an Open Enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that the policy will not pay benefits for stays beginning or medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an Open Enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage and the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if required within 90 days of losing your employer or union-based group health plan.

If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

SECTION 7 – SIGNATURE & DATE REQUEST

APPLICANT'S SIGNATURE: _____ **SIGNATURE DATE:** ____ / ____ / ____

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Satisfied - Item:	Application	Filed	07/15/2009
Comments:	See Form Schedule for application form completed based on applicant's responses and provided at time of policy issue.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	N/A		
Comments:			