

SERFF Tracking Number: HUMA-126840024 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 46930
 Company Tracking Number: AR-20-2010
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: 2010 Individual Medicare Supplement Plans
 Project Name/Number: Online App Screens /AR-20-2010

Filing at a Glance

Company: Humana Insurance Company

Product Name: 2010 Individual Medicare Supplement Plans

SERFF Tr Num: HUMA-126840024 State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010

SERFF Status: Closed-Approved- Closed State Tr Num: 46930

Sub-TOI: MS08I.001 Plan A 2010

Co Tr Num: AR-20-2010

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Stephanie Fowler

Authors: Michele Zabel, Paula

Disposition Date: 11/05/2010

Williamson, Bettina Ponds, Tammy

House, Tiffany Turner, Seth

Johnson

Date Submitted: 09/30/2010

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Online App Screens

Status of Filing in Domicile: Not Filed

Project Number: AR-20-2010

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: 11/05/2010

Explanation for Other Group Market Type:

State Status Changed: 11/05/2010

Deemer Date:

Created By: Bettina Ponds

Submitted By: Bettina Ponds

Corresponding Filing Tracking Number:

Filing Description:

RE: Humana Insurance Company/NAIC # 119, 73288

Medicare Supplement Electronic Enrollment - Application Screens

Please find enclosed for your review and approval the application screens (GNA09OIHH1) necessary for purchasing a

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Humana Medicare Supplement insurance plan online via Humana's website.

Policy forms issued by Humana Insurance Company: ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, and ARMESM10L.

Note: This is an updated version of the recently approved GNA09OIHH (HUMA-126790815). The new version has been revised as follows: on page 2 the following question has been added, "What are your dates of coverage under this policy..." and under Medical Questions on page 5 the following language has been added to each appropriate question, "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:...".

If you have any questions or require additional information, I can be reached in addition to SERFF at (502) 580-0964 or by email at bponds@humana.com.

Company and Contact

Filing Contact Information

Bettina Ponds, Medicare Supplement Product bponds@humana.com
 Compliance Analyst
 500 W. Main St. 502-580-0964 [Phone]
 Louisville, KY 40202

Filing Company Information

Humana Insurance Company	CoCode: 73288	State of Domicile: Wisconsin
1100 Employers Boulevard	Group Code: 119	Company Type: Life & Health
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-1263473	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50 per form. Only filing one application form.
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	09/30/2010	40025717

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	11/05/2010	11/05/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	10/14/2010	10/14/2010	Bettina Ponds	11/04/2010	11/04/2010

SERFF Tracking Number: HUMA-126840024 *State:* Arkansas
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Disposition

Disposition Date: 11/05/2010

Implementation Date:

Status: Approved-Closed

Comment: Thank you for your response to my objection letter dated October 14. You addressed my concern with your response; please find that this form filing has been approved.

Rate data does NOT apply to filing.

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/14/2010
Submitted Date 10/14/2010
Respond By Date 11/15/2010

Dear Bettina Ponds,

This will acknowledge receipt of the captioned filing.

Objection 1

- Online Application Screens , GNA09OIHH1 (Form)

Comment: Medical Questions - Disclaimer - Please remove the caps option from or reword the last sentence of the first paragraph. Having the sentence "PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY." could cause some confusion when emphasized like it is.

Please feel free to contact me if you have questions.

Sincerely,
Stephanie Fowler

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/04/2010
Submitted Date 11/04/2010

Dear Stephanie Fowler,

Comments:

Response 1

Comments: Can you further explain your concern with the language used? We do not feel that it would cause confusion. If the concern is about applicants enrolling during open enrollment or guaranteed issue, the questions with this text will not display.

Related Objection 1

Applies To:

- Online Application Screens , GNA09OIHH1 (Form)

Comment:

Medical Questions - Disclaimer - Please remove the caps option from or reword the last sentence of the first paragraph. Having the sentence "PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY." could cause some confusion when emphasized like it is.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thanks,
Bettina Ponds
bponds@humana.com

Sincerely,
Bettina Ponds, Michele Zabel, Paula Williamson, Seth Johnson, Tammy House, Tiffany Turner

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/05/2010	GNA09OIH H1	Application/Online Application Enrollment Screens Form	Revised	Replaced Form #: GNA09OIHH Previous Filing #: HUMA-126790815		GHA09OIHH1 .pdf

You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Welcome to Humana's Online Enrollment

You're ready to enroll online for the Humana Medicare Supplement Plan F. If this is not the plan you wish to enroll in, [return to our Plan Comparison](#).

Interested in enrolling in a Humana Medicare Supplement and Prescription Drug Plan? [Read how to enroll in both plans](#).

Before you begin...

- ✓ Verify the ZIP Code for your permanent mailing address.
ZIP Code: ##### [Change your ZIP Code](#)
- ✓ Have your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board handy. You'll need it to complete your enrollment form.
- ✓ If you have enabled a popup blocker on your computer, please disable it.

Ready? Let's get started [Next >](#)

[← Previous](#)

Things to know about enrolling online...

- **Help is close by.** If you need help signing up, or have a question along the way, Humana representatives are available to answer your questions by phone. Just call the number listed at the top of the screen.
- **Our online enrollment form is safe and secure.** To make sure all the information on your enrollment form remains private and confidential, we protect this Website with VeriSign. VeriSign is a trusted, nationally known company that makes sure all transactions sent through our site are completely secure. No one else can see or use any data you share with us. [Confirm the security of this site by visiting VeriSign's website.](#)
- **Online enrollment is official.** By completing this enrollment form you are sending an actual enrollment election to Humana. You will receive an enrollment packet and a copy of your completed enrollment form in the mail from Humana within seven to ten business days of enrolling online.



Toll-free: 1 - 888 - 310 - 8488
TTY users: 711

Last updated 10-01-2007

8 a.m. to 8 p.m., Monday - Friday

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GHA090IHH1

[Welcome to Humana's Online Enrollment](#)

You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Confirm Your Information

Please verify the following information.

Gender: **Female**

Date of Birth: **1/1/1940**

Medical Insurance (Part B): **1/1/2005**

Desired Coverage Start Date: **10/1/2010**

* Did you have Medicare Coverage prior to age 65? **No**

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

* Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? **No**

[Edit your Information](#)

Additionally, please answer the following questions.

* 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.

Yes No

* START

-Month- -Day- -Year-

END

-Month- -Day- -Year-

* Was this your first time in this type of Medicare plan?

Yes No

* Was this your first time in this type of Medicare plan?

Yes No

* Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

Yes No

* Do you have another Medicare supplement policy in force?

Yes No

* If so, with what company?

* What plan do you have? Please identify the plan type that corresponds to your current Medicare Supplement, or possibly Medicare Select, plan.

-Select-

* If so, do you intend to replace your current Medicare Supplement policy with this policy?

Yes No

* Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)

Yes No

* If so, with what company?

* What policy do you have?

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

* START

-Month- -Day- -Year-

END

-Month- -Day- -Year-

* Do you intend to replace your current healthcare coverage with this Medicare Supplement policy?

Yes No

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Monthly Premium: \$164.68

Contact Information

*Indicates required field

To complete this section, refer to your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. Please fill in the information exactly as it appears on these materials.

MEDICARE  HEALTH INSURANCE	
*First Name:	<input type="text"/>
Middle Initial:	<input type="text"/>
*Last Name:	<input type="text"/>
*Medicare Claim Number:	<input type="text"/>
*Effective Date:	
Hospital Insurance (Part A)	- Month - <input type="text"/> - Year - <input type="text"/>
Medical Insurance (Part B)	1/1/2005 

Additional Information

*Gender: Female 

*Date of Birth: 1/1/1940 

Phone Number: (including area code) - -

E-mail Address:

**OK to E-mail: We will use your e-mail address to send you important communications such as enrollment status and benefit usage.

Language Preference (Optional): 

Permanent Address Information

(Residential Street Address only - P.O. Box numbers cannot be accepted)

*Address 1:

Address 2:

*City:

*State: ST 

*ZIP Code: ##### 

Mailing Address Information

(if different from permanent home address)

Please enter the mailing address where Humana should send communications.

Address 1:

Address 2:

City:

State: - Select -

ZIP Code:

Emergency Contact Information (Optional)

Who should we notify in case of an emergency?

First Name:

Middle Initial:

Last Name:

Phone Number: (including area code) - -

Relationship to Applicant:

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**When you select OK to e-mail, your e-mail address will be added to Humana's e-mail mailing list. The mailing list is private and will not be sold to other companies. You may unsubscribe at any time. Just follow the instructions on the e-mail you receive.

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You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Enrollee Information

*Indicates required field

*Please tell us who is completing this enrollment form.

- I am completing my enrollment form on my own.
- I have Power of Attorney and am enrolling on someone's behalf.
- I am a Translator and/or Witness and am assisting in completing this enrollment form on someone's behalf.

*You do not need more than one Medicare Supplement policy.

*You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

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 requested within 90 days of losing your employer or union-based group health plan.

*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).

*If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. A copy of the notice from your prior insurer may be requested.

* Did you turn age 65 in the last six months?

- Yes No

* Did you enroll in Medicare Part B in the last six months?

- Yes No

* If yes, what is the effective date?

-Month- -Day- -Year-

* 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.)

* If yes, will Medicaid pay your premiums for this Medicare Supplement policy?

- Yes No

* Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium?

- Yes No

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You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Medical Questions

Yes or No answers are required to the following questions, unless you indicated that you are applying for coverage during your Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance. PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

* In the last year, have you been hospitalized, confined to a nursing facility, or are you bedridden or confined to a wheelchair?

Yes No

* In the past 90 days have you received Home Health care?

Yes No

* 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: 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

* 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: Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? Have you used supplementary oxygen in the last year?

Yes No

* 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: Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Lupus, Hepatitis, or Lou Gehrig's Disease?

Yes No

* 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: 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

* 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: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection?

Yes No

* 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: Kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin daily?

Yes No

* 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: Internal cancer, leukemia or melanoma?

Yes No

* 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: 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

* 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: Rheumatoid arthritis, Paget's Disease, degenerative bone disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries?

Yes No

* 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: Organ transplantation?

Yes No

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You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Select Payment Method

*Indicates required field

Payment Amount

Your Monthly Premium: \$164.68

You can choose to pay an additional amount for your first payment, above the required initial payment. This payment will be applied towards your future payments.

Your Minimum Initial Payment: \$ 164 . 68
Additional down payment above the required minimum: \$.

Initial Payment

Please select how you would like to be billed for your initial payment. Humana will only process your payment after your policy has been issued.

- *Initial Payment:
- One time automatic bank withdrawal
 -  MasterCard Credit Card
 -  Visa Credit Card
 -  Discover Credit Card

Future Payments

You can pay your premium monthly by automatic bank withdrawal, credit card charge or coupon book. Choosing automatic bank withdrawal or credit card charge provides a \$2 discount on your monthly premium. Generally, automatic bank withdrawals and credit card charges are made the first week of each month.

- *Future Payment:
- Coupon Book
 - Automatic Bank Withdrawal
 -  MasterCard Credit Card
 -  Visa Credit Card
 -  Discover Credit Card

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You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Enter Payment Details

*Indicates required field

Please provide the following required payment information.

Initial Payment

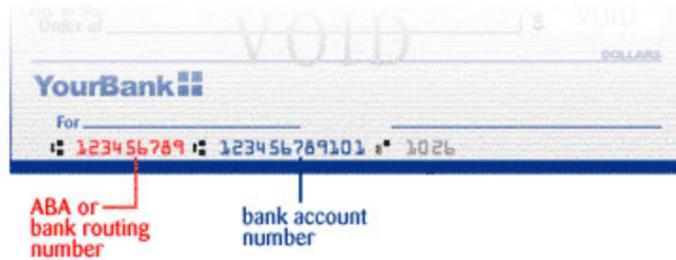
Automatic Bank Withdrawal

*Bank Name:

*Account Type: Checking
 Savings

*Routing Number:

*Account Number:



Future Payments

Coupon Book

Once we receive your completed enrollment form, we will mail you a coupon book for paying your monthly premiums via personal check. The coupon book will include instructions on paying using other payment options should you prefer to do so.

Authorization

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account and/or credit card, as indicated above, in amounts appropriate to my coverage; and authorize the bank named above to debit/credit the same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given reasonable written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

*I have read and agree to the statement above.

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You are enrolling in **Humana Medicare Supplement Plan F**

Monthly Premium: \$164.68

Review Your Enrollment Form

Almost done...

Before you sign and complete your enrollment, please review the information you have entered to make sure it is correct. If it is, click Next at the bottom of the screen.

To make a change, just click on the Edit Information link below the section you want to edit. Please note some changes may make you ineligible for enrollment in our plan. In addition, changes to some fields also may require you to answer additional questions.

Enrollment Information

Based on the answers you provided, we have determined that you are not enrolling in Guaranteed Issue and are receiving preferred rates.

Date of Birth: **1/1/1940**
Gender: **Female**

- * Did you have Medicare Coverage prior to age 65? **No**
- * Have you used tobacco products within the last 12 months? **No**
- * Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? **No**
- * 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. **No**
- * Do you have another Medicare supplement policy in force? **No**
- * Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) **No**

[Edit Information](#)

Contact Information

First Name: **xxxx**
Last Name: **xxxx**
OK to E-mail: **No**
Language Preference (Optional): **English**

[Edit Information](#)

Medicare Eligibility

Medicare Claim Number: **100200300A**
Hospital Insurance Effective Date (Part A): **1/1/2005**
Medical Insurance Effective Date (Part B): **1/1/2005**

[Edit Information](#)

Permanent Address Information

Address 1: **xxxx**
City: **xxxx**
State: **ST**
ZIP Code: **#####**

[Edit Information](#)

Effective Date:

Desired Coverage Start Date: **10/01/2010**

Your Coverage Start Date (Effective Date) is determined by the date you complete and sign your enrollment form.

Enrollee Information

Who is completing this enrollment form? **I am**

*You do not need more than one Medicare Supplement policy.

*You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

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 requested within 90 days of losing your employer or union-based group health plan.

*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).

*If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. A copy of the notice from your prior insurer may be requested.

- * Did you turn age 65 in the last six months? **No**
- * Did you enroll in Medicare Part B in the last six months? **No**
- * Are you covered for medical assistance through the State Medicaid program? **No**

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Medical Questions

Given your responses to the Medical questions, you are eligible to enroll in our plan. If you would like to review or change your answers, [click here](#).

Payment Method

Your Monthly Premium: **\$164.68**
Your Minimum Initial Payment: **\$164.68**
Additional down payment above the required minimum: **\$0.00**
Total Payment: **\$164.68**
Initial Payment: **Automatic bank withdrawal**
Bank Name: **xxxx**
Account Type: **Checking**
Routing Number: **xxxxx3123**
Account Number: **xxxxx3123**
Future Payment: **Coupon book**

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Toll-free: 1 - 888 - 310 - 8488
TTY users: 711

Last updated 10-01-2007

8 a.m. to 8 p.m., Monday - Friday

SERFF Tracking Number: HUMA-126840024 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 46930
 Company Tracking Number: AR-20-2010
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: 2010 Individual Medicare Supplement Plans
 Project Name/Number: Online App Screens /AR-20-2010

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	N/A - policy not filed		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	N/A - policy not filed		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	N/A		
Comments:			