

SERFF Tracking Number: HUMA-126872900 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 47233
 Company Tracking Number: AR-10-006-H1
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Arkansas MAINT filing
 Project Name/Number: /

Filing at a Glance

Company: Humana Insurance Company
 Product Name: Arkansas MAINT filing
 TOI: H16I Individual Health - Major Medical
 Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Filing Type: Form

SERFF Tr Num: HUMA-126872900 State: Arkansas
 SERFF Status: Closed-Approved- Closed State Tr Num: 47233
 Co Tr Num: AR-10-006-H1 State Status: Approved-Closed
 Author: Latunia Riley Reviewer(s): Rosalind Minor
 Date Submitted: 11/08/2010 Disposition Date: 11/17/2010
 Disposition Status: Approved-Closed
 Implementation Date:

Implementation Date Requested: On Approval
 State Filing Description:

General Information

Project Name:
 Project Number:
 Requested Filing Mode:
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 11/17/2010

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: 11/17/2010
 Created By: Latunia Riley
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Latunia Riley
 PPACA: Not PPACA-Related
 Filing Description:
 2010 MAINT filing

Company and Contact

Filing Contact Information

Latunia Riley, Contract Analyst

lriley2@humana.com

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Product Name: Arkansas MAINT filing
 Project Name/Number: /

2 Riverwood Place 262-951-2617 [Phone]
 W24133 Riverwood Dr.
 Suite 250
 Waukesha, WI 53188

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:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	11/08/2010	41625883
Humana Insurance Company	\$100.00	11/16/2010	41966841

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/17/2010	11/17/2010

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	Rosalind Minor	11/16/2010	11/16/2010	Latunia Riley	11/16/2010	11/16/2010

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Disposition

Disposition Date: 11/17/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	NAIC Transmittal Document	Approved-Closed	Yes
Form	Shared savings program	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	HumanaOne Individual Insurance Application	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 11/16/2010
Submitted Date 11/16/2010

Respond By Date

Dear Latunia Riley,

This will acknowledge receipt of the captioned filing.

Objection 1

- Shared savings program, GN-71037 SS 7/2010 (Form)
- Amendment, GN-71040-01 AMEND 4/2010 (Form)
- HumanaOne Individual Insurance Application, AR-71002 8/2010 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/16/2010
Submitted Date 11/16/2010

Dear Rosalind Minor,

Comments:

Dear Ms. Minor,

Response 1

Comments: Per our phone conversation this afternoon, the additional filing fee of \$100.00 was submitted via SERFF.

Related Objection 1

Applies To:

- Shared savings program, GN-71037 SS 7/2010 (Form)
- Amendment, GN-71040-01 AMEND 4/2010 (Form)
- HumanaOne Individual Insurance Application, AR-71002 8/2010 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

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No Rate/Rule Schedule items changed.

If you have 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

Enclosure

Sincerely,
Latunia Riley

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Form Schedule

Lead Form Number: GN-71037 SS 7/2010

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/17/2010	GN-71037 SS 7/2010	Policy/Cont ract/Fratern al	Shared savings program	Initial		40.400	IM Policy Rider.Shared Savings.pdf
Approved-Closed 11/17/2010	GN-71040- 01 AMEND 4/2010	Policy/Cont ract/Fratern al	Amendment	Initial		62.100	GN-71040-01 AMEND 4- 2010.pdf
Approved-Closed 11/17/2010	AR-71002 8/2010	Application/ Enrollment Form	HumanaOne Individual Insurance Application	Initial		42.700	AR-71002- 0810.pdf

POLICY RIDER

HUMANA INSURANCE COMPANY

[*Policyholder*: [John Doe]]

[*Policy Number*: [xxxxx]]

[*Effective Date*: [xx/xx/xxxx]]

This rider is attached to and made part of the *policy* to which it is attached. Except as modified below, all *policy* terms, conditions, exclusions and limitations apply.

The following is hereby added:

Shared savings program

As a member of a Preferred Provider Organization Plan, *you* are free to obtain *services* from providers participating in the Preferred Provider Organization network (*network providers*), or providers not participating in the Preferred Provider Organization network (*non-network providers*). If *you* choose a *network provider*, *your* out-of-pocket expenses are normally lower than if *you* choose a *non-network provider*.

We have a Shared Savings Program that may allow *you* to share in discounts we have obtained from *non-network providers*.

Although *our* goal is to obtain discounts whenever possible, we cannot guarantee that *services* rendered by *non-network providers* will be discounted. The *non-network provider* discounts in the Shared Savings Program may not be as favorable as *network provider* discounts.

In most cases, to maximize *your* benefit design and minimize *your* out-of-pocket expense, please access *network providers* associated with *your* plan.

If *you* choose to obtain *services* from a *non-network provider*, it is not necessary for *you* to inquire about a provider's status in advance. When processing *your* claim, we will automatically determine if that provider is participating in the Shared Savings Program and calculate *your deductible* and *coinsurance* on the discounted amount. *Your* Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

However, if *you* would like to inquire in advance to determine if a *non-network provider* participates in the Shared Savings Program, please call the telephone number on your *ID card*. Please note provider arrangements in the Shared Savings Program are subject to change without notice. We cannot guarantee that the provider from whom *you* received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

POLICY RIDER

We reserve the right to modify, amend or discontinue the Shared Savings Program at any time.

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

AMENDMENT

HUMANA INSURANCE COMPANY

Policyholder: [John Doe]

Policy number: [xxxxx]

This amendment should be attached to and made a part of *your policy*.

I hereby agree to the following change(s);

[Example: Effective xx/xx/xxxx, the deductible is \$1,000]

I hereby acknowledge that I have read and understand the above statements.

[Date:] [_____] [*Primary insured's signature:*] [_____/s/_____]]
[Primary applicant or parent/guardian
of minor]

[Date:] [_____] [Spouse's signature:] [_____/s/_____]]
[2473]

[Signature of Officer]
[Typed Name of Officer]
[Title of Officer]

HumanaOne Individual Insurance Application



Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of application: ___/___/___ Requested Effective Date: ___/___/___

This application is for: New Business (First time applicant) Reinstatement (Reapplication)
 Change/Modification to Existing Policy

[Arkansas]

Reason for change _____ Change/Modification to Existing Policy # _____

Coverage Options

<p>[Health Coverage] Please complete this section when selecting a health plan.</p> <p>Plan name _____ Deductible \$] _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <p>[Dental Coverage]</p> <p><input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]</p> </td> <td style="width:50%; vertical-align: top;"> <p>[Vision Coverage]</p> <p><input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]</p> </td> </tr> </table>	<p>[Dental Coverage]</p> <p><input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]</p>	<p>[Vision Coverage]</p> <p><input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]</p>	<p>[Optional Benefits] Please select an optional benefit if available with chosen health plan.</p> <p><input type="checkbox"/> Office visit copay <input type="checkbox"/> Prescription drug deductible: <input type="checkbox"/>[\$0-2,000] <input type="checkbox"/>[\$0-2,000] <input type="checkbox"/>[\$0-2,000] <input type="checkbox"/> Supplemental Accident Benefit: <input type="checkbox"/>[\$100-5,000] <input type="checkbox"/>[\$100-5,000] <input type="checkbox"/>[\$100-5,000] <input type="checkbox"/> Mental Disorder Benefit <input type="checkbox"/> Carryover Deductible]</p>
<p>[Dental Coverage]</p> <p><input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]</p>	<p>[Vision Coverage]</p> <p><input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name] <input type="checkbox"/> [Plan name]</p>		

[Your billing and effective date for the vision product will be determined once your medical plan is issued. The effective date can be up to [0-45] days after the medical plan is issued. The initial payment will be taken at the time the vision policy is issued; subsequent payment will be billed on the [15th] of each month.]

[Please note: You may purchase [dental] [or vision] coverage if health coverage is chosen. [If [dental] [or vision] is selected, it will be approved if the health coverage is approved.] [If you are changing or modifying an existing/approved policy or plan, [dental] [or vision] is only available at your anniversary.]]

[Life Coverage

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.

<p>Primary Applicant:</p> <p><input type="checkbox"/> [\$0-20,000] Term Life Rider (can only be purchased with a health plan) Primary beneficiary name _____ Relationship _____ Benefit % _____ Contingent beneficiary name _____ Relationship _____ Benefit % _____]</p> <p><input type="checkbox"/> Term Life Plan (Minimum selection is [\$0-1,000,000]. Maximum selection is [\$0-1,000,000]. Amounts must be purchased in [\$0-100,000] increments.) Term life insurance amount: \$ _____ Term length: <input type="checkbox"/> [0-50] years <input type="checkbox"/> [0-50] years <input type="checkbox"/> [0-50] years Primary beneficiary name _____ Relationship _____ Benefit % _____ Contingent beneficiary name _____ Relationship _____ Benefit % _____]</p>	<p>Spouse:</p> <p><input type="checkbox"/> [\$0-20,000] Term Life Rider (can only be purchased with a health plan) Primary beneficiary name _____ Relationship _____ Benefit % _____ Contingent beneficiary name _____ Relationship _____ Benefit % _____]</p> <p><input type="checkbox"/> Term Life Plan (Minimum selection is [\$0-1,000,000]. Maximum selection is [\$0-1,000,000]. Amounts must be purchased in [\$0-100,000] increments.) Term life insurance amount: \$ _____ Term length: <input type="checkbox"/> [0-50] years <input type="checkbox"/> [0-50] years <input type="checkbox"/> [0-50] years Primary beneficiary name _____ Relationship _____ Benefit % _____ Contingent beneficiary name _____ Relationship _____ Benefit % _____]]</p>
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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 [0-40] 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.

Spouse 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			

Dependent 1 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]		[Married <input type="checkbox"/> No <input type="checkbox"/> Yes]	[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Dependent 2 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]		[Married <input type="checkbox"/> No <input type="checkbox"/> Yes]	[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Dependent 3 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]		[Married <input type="checkbox"/> No <input type="checkbox"/> Yes]	[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Dependent 4 First name	MI	Last name	Height	Weight	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth / /
[Full-time student (if [0-40] or older) <input type="checkbox"/> No <input type="checkbox"/> Yes]		[Married <input type="checkbox"/> No <input type="checkbox"/> Yes]	[Residential address different than primary applicant? <input type="checkbox"/> No <input type="checkbox"/> Yes]			

Existing/Prior Coverage

IMPORTANT: DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

• Existing or Prior Health Coverage

If you are applying for health coverage, please provide the status of current coverage or coverage within the past [1-24] months, 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 major medical health insurance coverage currently in force?]

• If YES, please supply the following for all applicants applying for coverage on the policy:

Name(s) of covered persons _____

Major Medical Insurance Carrier Name _____

Effective Date ___/___/_____

• If NO, please answer the following question:

No Yes Have you or anyone applying for coverage had major medical health insurance coverage within the past [1-24] months?]

• If YES, please supply the following for all applicants applying for coverage on the policy:

Name(s) of covered persons _____

Major Medical Insurance Carrier Name _____

Effective Date ___/___/_____

Termination 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 applying for coverage 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.

[Quoted premiums are only an estimate. We may need to adjust your premium based on underwriting. If the difference is [1-20] percent or less, we'll adjust your premium automatically. If the difference is more than [1-20] percent, we'll contact you.]

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 [fully] disclose any eligibility or health information may cause your claim to be reduced or denied, [including the applicability of a condition specific deductible;] or may result in your policy being rescinded or modified 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 or dependent applying for coverage used any tobacco product?]

[Primary Applicant: No Yes] [Spouse: No Yes] [Dependent: No Yes]

[4. No Yes Has anyone applying for coverage participated in any dangerous or extreme sport activity in the past [1-24] months or plan to participate in the future?]

[5. No Yes Are you or is any immediate family member (whether applying for coverage or not) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?]

[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 surgery or been advised to have surgery that has not been completed?]

[12. No Yes Consulted, 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 ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders]
[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 Uterine Fibroids]
[G. <input type="checkbox"/> No <input type="checkbox"/> Yes Paralysis]	[S. <input type="checkbox"/> No <input type="checkbox"/> Yes Cyst, Growth, Lump or Polyp]
[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Epilepsy or Seizure]	[T. <input type="checkbox"/> No <input type="checkbox"/> Yes Hernia]
[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Migraines or frequent or severe headaches]	[U. <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis]
[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis]	[V. <input type="checkbox"/> No <input type="checkbox"/> Yes Implants, Pins, Plates, Rods, Screws or Prosthesis]
[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Apnea]	[W. <input type="checkbox"/> No <input type="checkbox"/> Yes Connective Tissue or Autoimmune Disorder]
[L. <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety or Depression]	[X. <input type="checkbox"/> No <input type="checkbox"/> Yes Birth Defect]

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 Eyes, Ears, Nose, Throat or Sinuses]
[B. <input type="checkbox"/> No <input type="checkbox"/> Yes Colon, Esophagus or Stomach]	[H. <input type="checkbox"/> No <input type="checkbox"/> Yes Breasts]
[C. <input type="checkbox"/> No <input type="checkbox"/> Yes Bladder or Kidneys]	[I. <input type="checkbox"/> No <input type="checkbox"/> Yes Menstrual Cycle]
[D. <input type="checkbox"/> No <input type="checkbox"/> Yes Back, Disc, Neck or Spine]	[J. <input type="checkbox"/> No <input type="checkbox"/> Yes Cervix, Ovaries, Uterus or Vagina]
[E. <input type="checkbox"/> No <input type="checkbox"/> Yes Knee, Hip or Shoulder]	[K. <input type="checkbox"/> No <input type="checkbox"/> Yes Penis, Prostate or Testicles]
[F. <input type="checkbox"/> No <input type="checkbox"/> Yes Lungs]	[L. <input type="checkbox"/> No <input type="checkbox"/> Yes Skin]

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 (not previously disclosed) 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, including Bone/Joint Disorders]
[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 Within the past [1-24] [months] [1-5] [years], has anyone applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for any reason not previously disclosed?]

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 not previously disclosed?]

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 agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. [I have received and reviewed any state or federal required disclosures.] I acknowledge that neither I nor the agent have the right to waive or incompletely answer 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 will not use pre-tax income to pay premiums associated with this policy or otherwise 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. [Unless Humana agrees to an earlier date, the effective date for sickness begins on the 15th day after the approved effective date of 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. I agree to terminate any existing coverage if this application is approved and coverage accepted. [As a parent or legal guardian of a dependent [under the age of] [0-40] years [or older] applying for coverage, I attest by my signature below, that I have gathered the necessary health information regarding my dependent in order to fully and truthfully complete this application.] [A minimum [0-2] year contract is required for vision plans offered by Humana Insurance Company.]

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 be unable to enroll you in a HumanaOne medical plan.

Primary Applicant or Legal Guardian Signature _____ Date __/__/____
 Relationship of Legal Guardian _____
 Spouse Signature (if covered dependent) _____ 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.

[1. Agent / Agency of Record: [(for commissions and correspondence)] Name (print) _____ Humana Agent # _____ [Commission split: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage _____ (Total should equal 100%)]	[2. Agent / Agency of Record: [(for split-commissions)] Name (print) _____ Humana Agent # _____ [Percentage of sales: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage _____ (Total should equal 100%)]
[1. Writing Agent / Producer: Name (print) _____ Humana Agent # _____ Arkansas license # _____ Signature _____ [Commission split: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, percentage _____ (Total should equal 100%)]	[2. Writing Agent / Producer: (for split-commissions) Name (print) _____ Humana Agent # _____ Arkansas license # _____ Signature _____ [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]
[Dental product [insured] or [administered] by American Dental Providers of Arkansas, Inc.]
[Vision products [insured] or [administered] by Humana Insurance Company]

HUMANA
Guidance when you need it most

SERFF Tracking Number: HUMA-126872900 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 47233
 Company Tracking Number: AR-10-006-HI
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Arkansas MAINT filing
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	11/17/2010
Comments:		
Attachment: Certificate of Readability.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	11/17/2010
Bypass Reason: not applicable		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	11/17/2010
Bypass Reason: not applicable		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	11/17/2010
Bypass Reason: not applicable		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	11/17/2010
Bypass Reason: not applicable		
Comments:		

SERFF Tracking Number: HUMA-126872900 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 47233
 Company Tracking Number: AR-10-006-HI
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: Arkansas MAINT filing
 Project Name/Number: /

	Item Status:	Status
		Date:
Satisfied - Item: Cover Letter	Approved-Closed	11/17/2010
Comments:		
Attachment:		
Filing Cover Letter.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: Statement of Variability	Approved-Closed	11/17/2010
Comments:		
Attachment:		
Generic SOV.Application-Enrollment 7-2010.pdf		

	Item Status:	Status
		Date:
Satisfied - Item: NAIC Transmittal Document	Approved-Closed	11/17/2010
Comments:		
Attachment:		
Arkansas NAIC Transmittal Document.pdf		

HUMANA INSURANCE COMPANY

CERTIFICATION

RE: GN-71037 SS 7/2010, GN-71040-01 AMEND 4/2010, and AR-71002 8/2010

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.

<u>Form Number(s)</u>	<u>Flesch Test Reading Ease Score</u>
GN-71037 SS 7/2010	40.4
GN-71040-01 AMEND 4/2010	62.1
AR-71002 8/2010	42.7



Signed by: _____

Steve DeRaleau
Vice President

Date: November 8, 2010

November 8, 2010

Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

**RE: Humana Insurance Company
Individual Health Form Filing
Rider: GN-71037 SS 7/2010
Amendment: GN-71040-01 AMEND 4/2010
Application: AR-71002 8/2010
NAIC #73288
FEIN # 39-1263473**

Dear Sir/Madam:

We are enclosing the above-referenced forms for your review and approval. These forms are new and will not replace any previously filed or approved forms. These forms are being filed for general use with all approved policy series.

The Application may be offered in a printed, online, or digitized audio recorded format. The language in the rider may be incorporated into the body of the policy when issued.

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

Latunia Riley
Contract Analyst

Statement of Variability for Application/Enrollment Forms

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, medical or eligibility questions, or agreements.
2. Bracketed sections are identified by green brackets.

NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. 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.
4. 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.
 - Revision numbers 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.

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 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.

Formatting

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.

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	
-----------	----------------------------------	--

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address

5.	Requested Filing Mode	<input 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): _____
-----------	------------------------------	---

6.	Company Tracking Number	
-----------	--------------------------------	--

7.	<input type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
-----------	---	-----------------------

8.	Market	<input 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: _____

9.	Type of Insurance	
-----------	--------------------------	--

10.	Product Coding Matrix Filing Code	
------------	--	--

11.	Submitted Documents	<p><input type="checkbox"/> FORMS</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 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>Rates</p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input type="checkbox"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input 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"/> Policy	<input type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate										
<input 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"/> FILING OTHER THAN FORM OR RATE: Please explain: _____										
		<p>SUPPORTING DOCUMENTATION</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 type="checkbox"/> Statement of Variability</td> <td><input 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"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications	<input type="checkbox"/> Actuarial Memorandum		<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 type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications											
<input type="checkbox"/> Actuarial Memorandum												
<input type="checkbox"/> Other _____												

12.	Filing Submission Date		
13	Filing Fee (If required)	Amount <u> \$50.00 </u>	Check Date <u> </u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number <u> </u>
14.	Date of Domiciliary Approval		
15.	Filing Description:		

16.	Certification (If required)
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of _____.</p>	
<p>Print Name _____ Title _____</p>	
<p>Signature _____ Date: _____</p>	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input 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				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	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