

SERFF Tracking Number: HUMA-126669624 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 45918
Company Tracking Number: 6792 06/10
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Application
Project Name/Number: Reinstatement Change Form/6792 06/10

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: Application

SERFF Tr Num: HUMA-126669624 State: Arkansas

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved- State Tr Num: 45918
Closed

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: 6792 06/10 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Judy Lanning, Glenda
Howell

Disposition Date: 06/21/2010

Date Submitted: 06/10/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Reinstatement Change Form

Project Number: 6792 06/10

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/21/2010

Status of Filing in Domicile:

Date Approved in Domicile: 07/28/2009

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/21/2010

Created By: Judy Lanning

Corresponding Filing Tracking Number: 6792
06/10

Deemer Date:

Submitted By: Judy Lanning

Filing Description:

Kanawha Insurance Company

Reinstatement Form 6792 06/10

Dear Commissioner:

Kanawha Insurance Company is submitting the above captioned form for the Department's review and approval. This form is new and will with previously approved Hospital Indemnity Policy Form No. 90840 AR approved by the Department on June 2, 2009.

SERFF Tracking Number: HUMA-126669624 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 45918
Company Tracking Number: 6792 06/10
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Application
Project Name/Number: Reinstatement Change Form/6792 06/10

The Reinstatement Change Form has been designed for use after policy issuance in the event of Policy lapse for non payment of premium due by the end of the Grace Period. The policy owner or insured, if different than policy owner, may request reinstatement of their policy.

In addition, this Reinstatement Form is multi-purpose and will be used with all of Kanawha' other individual life and health products which have been previously approved and may be approved by the Department in the future.

The form is in final print, subject to minor variations in formatting, duplexing, shading and fonts. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval. The Company will provide you a highlighted copy of any corrections it makes for your records.

Thank you for your attention to this filing. If you should have any questions, please contact me at 502-476-1408. My email address is jlanning@humana.com.

Sincerely,

Judy Lanning
Compliance Analyst

Company and Contact

Filing Contact Information

Judy Lanning, Compliance Analyst
104 South Fourth Street
Louisville, KY 40201

jlanning@humana.com
502-476-1408 [Phone]
502-508-2114 [FAX]

Filing Company Information

Kanawha Insurance Company
210 South White Street
Lancaster, SC 29721
(800) 635-4252 ext. [Phone]

CoCode: 65110
Group Code: 119
Group Name:
FEIN Number: 57-0380426

State of Domicile: South Carolina
Company Type:
State ID Number:

Filing Fees

SERFF Tracking Number: HUMA-126669624 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 45918
Company Tracking Number: 6792 06/10
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Application
Project Name/Number: Reinstatement Change Form/6792 06/10

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: Reinstatement Change Form Application = \$50
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kanawha Insurance Company	\$50.00	06/10/2010	37141114

SERFF Tracking Number: HUMA-126669624 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 45918
Company Tracking Number: 6792 06/10
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Application
Project Name/Number: Reinstatement Change Form/6792 06/10

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/21/2010	06/21/2010

SERFF Tracking Number: HUMA-126669624 *State:* Arkansas
Filing Company: Kanawha Insurance Company *State Tracking Number:* 45918
Company Tracking Number: 6792 06/10
TOI: H14I Individual Health - Hospital Indemnity *Sub-TOI:* H14I.000 Health - Hospital Indemnity
Product Name: Application
Project Name/Number: Reinstatement Change Form/6792 06/10

Disposition

Disposition Date: 06/21/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: HUMA-126669624 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number: 45918
 Company Tracking Number: 6792 06/10
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Application
 Project Name/Number: Reinstatement Change Form/6792 06/10

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
Form	Reinstatement Change Form	Approved-Closed	Yes

SERFF Tracking Number: HUMA-126669624 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number: 45918
 Company Tracking Number: 6792 06/10
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Application
 Project Name/Number: Reinstatement Change Form/6792 06/10

Form Schedule

Lead Form Number: 6792 06/10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 06/21/2010	6792 06/10	Application/ Enrollment Form	Reinstatement Change Form	Initial			6792 Reinstatement Change Form ,pdf.pdf

Reinstatement Change Form



Kanawha Insurance Company, [P.O. Box 610, Lancaster, SC 29721-0610]

Insured's Name _____ Policy Number _____
 Owner's Name _____ Owner's Social Security Number _____
 Owner's Address _____
 City _____ State _____ ZIP+4 _____
 Owner's Telephone _____

Reinstatement

The representations made apply to each person proposed for coverage.

Health and Life Insurance

The undersigned hereby represents that:

1. Within the past five years, or the period since the date of issue of the policy, whichever is shorter, has any person: **YES** **NO**
 - a. had any injury, disease or disorder?
 - b. consulted, been treated or examined by a physician or other medical practitioner?
 - c. been advised to enter, or in a hospital or health care facility for observation, diagnosis, operation or treatment? . . .
 - d. ever had or been diagnosed as having an Immune Deficiency Disorder, AIDS or AIDS Related Complex (ARC)? . .
 - e. received advice or treatment for the use of alcohol or drugs?
 - f. been declined, postponed, charged an extra premium, refused reinstatement, been issued a policy with an exclusion rider, or offered a policy on a basis different from that applied for?
 - g. engaged in aviation as a pilot or crew member?
 - h. changed customary occupation?
2. Give full details to "Yes" answers from the above statements 1a - 1h. Always indicate the name of the person, disease, injury or disorder, dates, results of treatment, names and addresses of each physician and each hospital: _____

3. Change in weight: (disregarding a child's normal growth). If weight has changed, give present height and weight, amount of weight lost or gained, and give reason for change: _____

4. Used tobacco in any form in the last twelve months? Yes No

MIB Disclosure Notice – Detach and Give to Proposed Insured

Information regarding your insurability will be kept confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is [50 Braintree Hill Park[,] [Suite 400], [Braintree, MA 02184-8734], email address [www.mib.com] and telephone number [(781) 751-6000]. Kanawha Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FRAUD STATEMENT

Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. **(See State Specific Fraud Warning Statements below)**

AGREEMENTS

I/We have read or had read to me all the questions on this Application and I/We represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I/We also realize that any false statements or misrepresentation may result in loss of coverage under the policy subject to the Time Limit on Certain Defenses or Incontestability provisions of the policy. I/We understand and agree that the policy will not take effect unless it is issued by Kanawha Insurance Company, the total modal premium must accompany the Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application.

AUTHORIZATION

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. **(See State Specific Authorization provisions below)**

I UNDERSTAND THE REINSTATED POLICY SHALL ONLY COVER LOSSES SUSTAINED AFTER THE DATE OF REINSTATEMENT AS SET OUT IN THE POLICY'S REINSTATEMENT PROVISION.

_____	_____ / _____ / _____
Signature of Licensed Insurance Producer	Date
_____	_____ / _____ / _____
Signature of Policyowner	Date
_____	_____ / _____ / _____
Signature of Insured if Different Than Policyowner	Date
_____	_____ / _____ / _____
Signature of Spouse (If Insured)	Date

Thank you for giving Kanawha the opportunity to consider your insurance needs. As part of our normal procedure for processing Applications, we may order an investigative consumer report. This includes your prescription drug history and information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. You may request to be interviewed in connection with the preparation of this investigative consumer report and upon request you are entitled to receive a copy of the investigative consumer report. If you question the accuracy of information in the investigative consumer report, you may contact the Consumer Reporting Agency and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. We may telephone you to confirm information given in your Application or to obtain additional information needed to process your Application. All information asked for in your Application, or obtained from other sources, such as your physician, or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature or source of the information.

State Specific Fraud Warning Statements

Arkansas

Any person who knowingly presents a false or fraudulent claim for payment of a 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.

California

For your protection, California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies

District of Columbia

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Louisiana

Any person who knowingly presents a false or fraudulent claim for payment of a 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.

Maryland

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a 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.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Carolina

Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Ohio

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oklahoma

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a 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.

Tennessee, Virginia and Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

State Specific Authorization Provisions

Arizona

By this form (or photocopy of it), which is valid for 30 months from the date shown below (180 days in the case of HIV related information), I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Florida, Kentucky, Nebraska, Oklahoma, Oregon, West Virginia and Wyoming

By this form (or photocopy of it), which is valid for 24 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Minnesota

By this form (or photocopy of it), which is valid as long as the individual is insured, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Missouri

I acknowledge that within 60 days of Home Office receipt, Kanawha Insurance Company will advise whether this application has been accepted or rejected. By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Vermont

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. This authorization excludes the release of information relating to previously administered tests for HIV antibodies, T-cell counts, Acquired Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) by any medical doctor, doctor of osteopathy, physician, health care professional, hospital, clinic, medical facility, the Veterans Administration, the MIB, Inc., employer, consumer reporting agencies, other insurance company, or anyone else, with respect to previous test results, nor is Kanawha authorized to release any HIV-related information to any other person. I realize that I, or a representative on my behalf, have a right to receive a copy of this authorization.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Wisconsin

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to Kanawha Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. Information about AIDS or HIV status is limited to a positive diagnosis made by a member of the medical profession. HIV test results received at an anonymous counseling and testing site or results from a home test kit are not subject to disclosure. I understand that such information will be used by Kanawha Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: Kanawha Insurance Company at [210 South White Street, Lancaster, SC 29720], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that Kanawha Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

SERFF Tracking Number: HUMA-126669624 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number: 45918
 Company Tracking Number: 6792 06/10
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Application
 Project Name/Number: Reinstatement Change Form/6792 06/10

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/21/2010
Comments: See attached.		
Attachment: READABILITY CERTIFICATION.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	06/21/2010
Bypass Reason: Does not apply to this filing. Previously approved 6/2/2009 SKML-126108237.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	06/21/2010
Bypass Reason: Does not apply to this filing. Previously approved 6/2/2009 SKML-126108237		
Comments:		

READABILITY CERTIFICATION

RE: Kanawha Insurance Company

This is to certify that the form(s) referenced below is/are in compliance with the readability requirements of your state.

The Flesch Reading Ease Test was applied to each form in its entirety. All titles, major headings and subheadings, defined terms and tables were excluded.

The Flesch Reading Ease Test score(s) is/are:

Forms:

Flesch Score

6792 06/10

*50

*Combined Flesch Score with Policy 90840 AR



BY: _____
R. Dale Vaughan, President