

SERFF Tracking Number: HUMA-127119805 State: Arkansas
 Filing Company: Humana Insurance Company State Tracking Number: 48450
 Company Tracking Number: AR-04-2011
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010
 Standard Plans 2010
 Product Name: 2010 Individual Medicare Supplement Plans
 Project Name/Number: 2010 FASTAPP - Revised Fulfillment App /AR-04-2011

Filing at a Glance

Company: Humana Insurance Company
 Product Name: 2010 Individual Medicare Supplement Plans SERFF Tr Num: HUMA-127119805 State: Arkansas
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved- Closed State Tr Num: 48450
 Sub-TOI: MS08I.012 Multi-Plan 2010 Co Tr Num: AR-04-2011 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Stephanie Fowler
 Authors: Michele Zabel, Paula Williamson, Bettina Ponds, Tammy House, Tiffany Turner, Seth Johnson Disposition Date: 04/21/2011
 Date Submitted: 04/08/2011 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: 2010 FASTAPP - Revised Fulfillment App Status of Filing in Domicile: Not Filed
 Project Number: AR-04-2011 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 04/21/2011
 State Status Changed: 04/21/2011
 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 Materials

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

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 submitted for review:

1. Fulfillment Enrollment Forms

- GN85026M10EE1 – Revised application form is populated with the applicant’s responses. The completed application will be provided to the applicant when the policy is issued. The form has been updated to include fields for Height /Weight /Body Mass Index and Plan N.

Previously filed and approved under HUMA-126625481.

Policy forms issued by Humana Insurance Company: ARMESM10A, ARMESM10B, ARMESM10C, ARMESM10F, ARMESM10F(HD), ARMESM10K, ARMESM10L, and ARMESM10N.

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 for each form submitted
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$50.00	04/08/2011	46420652

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	04/21/2011	04/21/2011

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Disposition

Disposition Date: 04/21/2011

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		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Enrollment Application Fulfillment Form	Approved	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/21/2011	GN85026M 10NEE1	Application/ Enrollment Form	Enrollment Application Fulfillment Form	Revised	Replaced Form #: GN85026M10NEE Previous Filing #: HUMA-126625481		GN85026M10 NEE1.pdf

MEDICARE SUPPLEMENT ENROLLMENT APPLICATION

Please review the following copy of your application. If any of the information contained in your application, including that which is related to your medical history (when applying outside of guaranteed acceptance periods), is incorrect or incomplete, please contact Humana within 10 days by calling 1-800-866-0581. If you are speech or hearing impaired and use a TTY, please call 711. You can also contact us by mail at Humana, P.O. Box 14168, Lexington, KY 40512-4168. Depending upon the circumstances of your enrollment, you may not have been asked all of the questions contained in this application. Questions which you were not required to answer appear blank or do not display a Yes or No response.

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

SECTION 1 – PERSONAL INFORMATION

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS 1: _____

ADDRESS 2: _____

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

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

HEIGHT ____ (FT) ____ (IN) WEIGHT ____ (LBS) BMI ____

MAILING ADDRESS (Only if different from Street Address):

ADDRESS 1: _____

ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL ADDRESS: _____

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

Select the policy you are applying for:

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

PROPOSED EFFECTIVE DATE:

_____/_____/_____

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

MEDICARE CLAIM NUMBER _____

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) ____/____/____

MEDICAL INSURANCE (PART B) ____/____/____

Person to Notify in an Emergency (optional):

LAST NAME: _____ FIRST NAME: _____

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

SECTION 2 – OTHER COVERAGE INFORMATION

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

Yes or No answers 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.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

- a. Did you turn age 65 in the last six months? Yes No
 - b. Did you enroll in Medicare Part B in the last six months? Yes No

If yes, what is the effective date? ___/___/____
- a. 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.)
 - b. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
 - c. Do you receive any benefits from Medicaid OTHER THAN payments toward Your Medicare Part B premium?
 Yes 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.

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

 - a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
 - b. Was this your first time in this type of Medicare plan? Yes No
 - c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No
- Do you have another Medicare supplement policy in force? Yes No

 - a. If so, with what company? _____
What plan do you have? _____
 - b. If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) Yes No

 - a. If so, with what company? _____
What policy do you have? _____
 - b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
START ___/___/____ END ___/___/____
- Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? Yes No

SECTION 3 – GUARANTEED ACCEPTANCE DETERMINATION

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment period? Yes No
If yes, please go directly to Section 6.
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance?
 Yes No
If yes, please go directly to Section 6.

If you answered yes to either question in this section, you qualify for the Preferred rates.

SECTION 4 – 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.

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

SECTION 5 - MONTHLY PREMIUM DETERMINATION

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance as indicated in Section 3.

1. Did you have Medicare coverage prior to age 65? Yes No
2. Have you used tobacco products within the last 12 months? Yes No

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

SECTION 6 - PAYMENT OPTIONS

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

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

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

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

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

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

SECTION 7 – SIGNATURE & DATE

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

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

Sales Agent - Please list: All health insurance policies sold to the applicant which are still in force and all health insurance policies sold to the applicant within the past five years which are no longer in force (if none or not applicable, write NONE.)

COMPANY: _____ **TYPE:** _____

COMPANY _____ **TYPE** _____

Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168

GN85026M10NEE1

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification		
Bypass Reason: n/a		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments:		
Please see the Application form attached under the Form Schedule tab.		

	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:		