

SERFF Tracking Number: MGCC-125950178 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 41136
 Company Tracking Number: CH-25098-INDAPP (09/08)
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CH-25098-APP (09/08)
 Project Name/Number: CH-25098-APP (09/08)/CH-25098-APP (09/08)

Company and Contact

Filing Contact Information

Chalon Ybarra, Compliance Analyst II chalon.ybarra@healthmarkets.com
 9151 Boulevard 26 (817) 255-5487 [Phone]
 North Richland Hills, TX 76180 (817) 255-8153[FAX]

Filing Company Information

The Chesapeake Life Insurance Company CoCode: 61832 State of Domicile: Oklahoma
 9151 Boulevard 26 Group Code: 264 Company Type: Health
 North Richland Hills, TX 76180 Group Name: State ID Number:
 (817) 255-3100 ext. [Phone] FEIN Number: 52-0676509

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form x 1 form = \$20.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	\$20.00	12/16/2008	24572931

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/18/2008	12/18/2008

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	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	Cover Letter	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CH-25098-INDAPP (09/08)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CH-25098-INDAPP (09/08)	Application/ Enrollment Form	Application	Initial		50	CH-25098-INDAPP_09.08_.pdf

Application for: **The Chesapeake Life Insurance Company** • Oklahoma City, Oklahoma 73118

1. SCHEDULE OF FAMILY MEMBERS - FIGURE HEALTH PREMIUM USING AGE AT LAST BIRTHDAY								
Please Print (Full Name)	Sex	Relationship	DOB	Birthplace	Age	Ht.	Wt.	Social Security #
(1)		Primary						
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								

2. Marital Status: Single Married
3. Applicant's Home Address: _____
 City _____ State _____ Zip _____ County _____
 Daytime Phone (_____) _____ - _____ Home Phone (_____) _____ - _____
 Cell Phone (_____) _____ - _____ Fax Number (_____) _____ - _____
 Email Address _____
4. Are all Applicants U.S. Citizens? ___ Yes ___ No. If "No," explain: _____
 How long in the U.S.? _____ Work Permit ___ Visa ___ Type of Visa _____ Expiration Date _____
5. Are all Applicants between the ages of 19 and 24 full-time students? ___ Yes ___ No ___ None.
 If "Yes," name of school(s) _____
 If "No," who? _____ Explain _____
6. Occupation/duties of Primary Applicant: _____ Spouse Applicant: _____
7. Is any Applicant eligible for or covered under Medicare or Medicaid? ___ Yes ___ No. If "Yes," who? _____
 Reason: Financial _____ Medical _____
8. a) Do you currently have **health** insurance? ___ Yes ___ No. If "Yes," is it ___ Group or ___ Individual? If "Yes," list names of companies, certificate/policy number, and types of coverage: _____
 Date of issue _____. Date of cancellation _____.
 Will existing **health** coverage be replaced or changed if proposed **health** coverage is issued?
 ___ Yes ___ No. If "No," reason: _____
- b) Do you currently have **life** insurance or **annuities**? ___ Yes ___ No. If "Yes," will the insurance applied for replace or otherwise reduce in value any **life** insurance or **annuities** now in force? ___ Yes ___ No. If "Yes," list details: _____
- TO BE ANSWERED BY AGENT:**
 Do you have any knowledge or reason to believe that the proposed Insured(s) is intending to replace or otherwise reduce in value any existing **life** insurance or **annuities**? ___ Yes ___ No. **AGENT'S INITIALS:** _____

QUESTIONS 9 - 19 ARE NOT REQUIRED TO BE ANSWERED IF APPLYING FOR A [DENTAL] [OR] [VISION] PLAN ONLY

9. a) Is the Applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?
 ___ Yes ___ No. If "Yes," who? _____ Estimated date of delivery _____
- b) Is the Applicant, spouse, or any dependent child (even if not proposed for insurance) being tested for or receiving treatment for infertility? ___ Yes ___ No. If "Yes," who? _____ Provide Details _____
10. Does any Applicant to be insured engage in any hazardous sport or activity? (e.g.: flying, diving, skydiving, racing.) ___ Yes ___ No.
 Name: _____ Activity _____
11. During the past ten years, has any person to be insured had insurance declined, rated, ridered, or otherwise changed?
 ___ Yes ___ No. If "Yes," who? _____ Date: _____
 Reason: _____ Company: _____
12. a) Applicant's Doctor _____ Phone Number (____) _____ - _____
 Address _____ City _____ State _____ Zip _____
- b) Spouse's Doctor _____ Phone Number (____) _____ - _____
 Address _____ City _____ State _____ Zip _____
- c) Child(ren)'s Doctor _____ Phone Number (____) _____ - _____
 Address _____ City _____ State _____ Zip _____
13. Has any Applicant used tobacco products in the **past twelve (12) months**? ___ Yes ___ No. If "Yes," who? _____
 Provide smoking/tobacco history over the past twelve (12) months: _____
14. a) Has any Applicant ever had or currently has a suspended or revoked Driver's License? ___ Yes ___ No.
 If "Yes," who? _____ Reason(s)? _____
- b) Has any Applicant ever received any citations for driving while under the influence? ___ Yes ___ No.
 If "Yes," who? _____ How many DWIs/DUIs? ___ ___
 Date(s) of citation(s): _____
- c) Has any Applicant ever been convicted or prosecuted for any criminal activity? ___ Yes ___ No.
 If "Yes," who? _____ List details: _____
15. a) When was the last time the Applicant visited a doctor? _____
 Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
- b) When was the last time the spouse visited a doctor? _____
 Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
- c) When was the last time the child(ren) visited a doctor?
 Child's Name: _____ Date(s): _____
 Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
 Child's Name: _____ Date(s): _____
 Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
 Child's Name: _____ Date(s): _____
 Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
 Child's Name: _____ Date(s): _____
 Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____

16. Have you or any Applicant **EVER** had symptoms, been diagnosed, received medical advice or been treated for (if "Yes," show details below):

- a) Heart attack, stroke, myocardial infarction, hypertension (high blood pressure), angina pectoris, transient ischemia attack (TIA), coronary artery disease, any form of heart surgery, coronary artery surgery, heart related arteriogram, angioplasty or pacemaker, or disease or disorder of the heart or circulatory system?.....
- b) Diabetes, hypoglycemia, goiter, thyroid disorder, or obesity?.....
- c) Blood or spleen disorder, including anemia or leukemia?.....
- d) Breast or reproductive organ disorder?.....
- e) Cancer, cyst, tumor, or neoplasm?.....
- f) Respiratory disorder, including asthma, bronchitis, COPD, emphysema, lung disease, or breathing problems?.....
- g) Kidney, urinary bladder, urinary tract, stones, or prostate disorders?.....
- h) Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis?.....

YES NO

FAMILY MEMBER										
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	
1	2	3	4	5	6	7	8	9	10	

20. This question is ONLY required to be answered if applying for [CRITICAL CARE/PLUS] Plan[s].

- a) Have either of your parents, brothers, or sisters been diagnosed or been treated for cancer, heart trouble, stroke, renal failure, multiple sclerosis, Alzheimer disease, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or diabetes? ___Yes ___No. If "Yes," complete the chart below.

FAMILY RECORD OF PROPOSED INSURED

	IMPAIRMENT	AGE AT ONSET	AGE AT DEATH
Father			
Mother			
Brothers			
Sisters			

- b) Have you or any Applicant ever received (or been diagnosed would need) a transplant of any of the following organs: heart, lung or lungs, liver, kidney, pancreas, heart/lung combined or bone marrow? ___Yes ___No
- c) Have you or any Applicant ever consulted with or been treated by a doctor for or had symptoms of cancer, a tumor, diabetes, high blood pressure, stroke, disease of the heart or blood vessels, renal failure, multiple sclerosis, carcinoma in situ, coronary artery by-pass surgery, coronary angioplasty or Alzheimer disease? _____Yes _____No

Please provide details to "Yes" answers on questions b) or c) above: _____

21. This question is ONLY required to be answered if applying for [INCOME PROTECTION][or] [INCOME PROTECTION PLUS] Plan[s].

- a) Do you currently have Disability Income Insurance (either through your employer or as an individual policy)? ___Yes ___No. If "Yes," please provide the following additional information:

Company	Monthly Benefit	Elimination Period	Length of coverage

- b) Are you currently disabled or receiving disability benefits? _____ Yes _____ No
- c) What is your annual gross income? \$ _____
- d) How many hours per week do you work? _____ hours
- e) Tell us your occupation and describe your specific job duties? _____

- f) As part of your normal activities, do you spend more than 25% performing manual labor/duties such as lifting, bending, stooping, pulling, pushing and/or carrying objects over 10 pounds? ___Yes ___No

DECLARATIONS AND AGREEMENTS

I agree that (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage and (d) no insurance will take effect unless and until the Application is approved by the Company and the policy is delivered to the Applicant while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Signed _____ / _____ / _____ at _____, _____ State

X _____ X _____
Signature of Applicant Signature of Spouse (If to be covered)

TO BE ANSWERED BY AGENT:

I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

X _____
Signature of Licensed Agent Print Full Name Agent Number

To be attached to, and be a part of the application for _____

Address: _____ Phone No. (_____) _____ - _____

COMPLETE THE FOLLOWING FOR ANY "YES" ANSWER TO QUESTIONS 16 THRU 18 AND ATTACH TO THE APPLICATION

Name	Nature of Illness or Accident (include diagnosis(es), operation(s), and medication(s))	Date Started	Date Stopped	Operation	Hospitalized	Doctor's Name and Address
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Applicant's Signature: _____ Date: _____

Spouse's Signature (If to be covered): _____ Date: _____

Agent's Signature: _____ Agent Number: _____

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Supporting Document Schedules

<p>Satisfied -Name: Certification/Notice Comments: Attachments: AR CH-25098-INDAPP _0908__Cert Compl Rule-Reg19.pdf AR CH-25098-INDAPP _0908__flesch.pdf</p>	<p>Review Status: Approved-Closed 12/18/2008</p>
<p>Satisfied -Name: Application Comments: This submission is for a new application.</p>	<p>Review Status: Approved-Closed 12/18/2008</p>
<p>Bypassed -Name: Health - Actuarial Justification Bypass Reason: N/A - Application only filing Comments:</p>	<p>Review Status: Approved-Closed 12/18/2008</p>
<p>Bypassed -Name: Outline of Coverage Bypass Reason: N/A - Application only filing Comments:</p>	<p>Review Status: Approved-Closed 12/18/2008</p>
<p>Satisfied -Name: Cover Letter Comments: Attachment: AR CH-25098-INDAPP _0908__ltr.pdf</p>	<p>Review Status: Approved-Closed 12/18/2008</p>

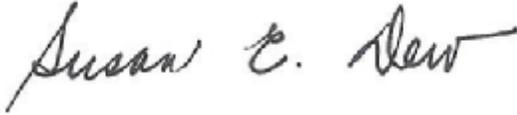
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH-25098-INDAPP (09/08)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Susan Dew

Name

VP, Associate General Counsel and Chief Compliance Officer

Title

December 16, 2008

Date

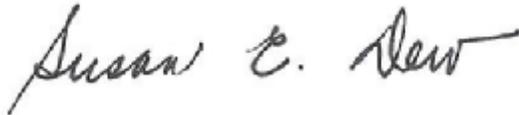
Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: Application

Form Number: CH-25098-INDAPP (09/08)

Flesch Reading Ease Score: 50



Susan Dew
VP, Associate General Counsel and Chief Compliance Officer
The Chesapeake Life Insurance Company

December 16, 2008

Date



**The Chesapeake
Life Insurance Company**

Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180
817-255-3100
Fax: 817-255-8153

December 16, 2008

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

RE: The Chesapeake Life Insurance Company
NAIC No. 264-61832 FEIN No. 52-0676509

SERFF Tracking # MGCC-125950178

Form Number:
CH-25098-INDAPP (09/08)

Description:
Application

Dear Commissioner Bowman:

The above referenced form is submitted for your review and approval. This form is new and not intended to replace any forms currently approved by your Department.

This application will be used to solicit coverage under our individual hospital, medical/surgical products, and it may also be used to solicit ancillary products previously approved in your state. This application may also be used to solicit coverage for products that may be approved in the future.

Please be advised that this form may also be solicited using electronic means.

The bracketed information is variable. The variable bracketed section, at the top of the first page, will contain marketing information, i.e. plan names, plan amounts, coinsurances, deductibles, etc. To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

If you have any questions or if anything further is needed to expedite the review of this filing, please call collect at (817) 255-5487. Your assistance in this matter is greatly appreciated.

Sincerely,

Chalon Ybarra
Compliance Analyst II
Compliance Department
Email: chalon.ybarra@HealthMarkets.com
Fax: (817) 255-8153