

SERFF Tracking Number: MGCC-126110236 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42366
Company Tracking Number: CH/MG-25098-APP (03/09) AR (FOR CLICO)
TOI: H15I Individual Health - *Sub-TOI:* H15I.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
Product Name: 25098-APP (03/09)
Project Name/Number: 25098-APP (03/09)/25098-APP (03/09)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: 25098-APP (03/09)

SERFF Tr Num: MGCC-126110236 State: ArkansasLH

TOI: H15I Individual Health -

SERFF Status: Closed

State Tr Num: 42366

Hospital/Surgical/Medical Expense

Sub-TOI: H15I.001 Health -

Co Tr Num: CH/MG-25098-APP

State Status: Approved-Closed

Hospital/Surgical/Medical Expense

(03/09) AR (FOR CLICO)

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Courtney Sharp, Chalon

Disposition Date: 05/15/2009

Ybarra, Jaime Butler

Date Submitted: 05/08/2009

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 25098-APP (03/09)

Status of Filing in Domicile:

Project Number: 25098-APP (03/09)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/15/2009

Explanation for Other Group Market Type:

State Status Changed: 05/15/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Application Form CH/MG-25098-APP (03/09) AR

SERFF Tracking Number: MGCC-126110236 State: Arkansas
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 Product Name: 25098-APP (03/09)
 Project Name/Number: 25098-APP (03/09)/25098-APP (03/09)

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	05/08/2009	27744983

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/15/2009	05/15/2009

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Item Type	Item Name	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	Cover Letter	Approved-Closed	Yes
Supporting Document	Exhibit A	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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 Project Name/Number: 25098-APP (03/09)/25098-APP (03/09)

Form Schedule

Lead Form Number: CH/MG-25098-APP (03/09) AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	CH/MG-25098-APP (03/09) AR	Application/ Enrollment Form	Application Enrollment	Initial		50	CHMG-25098-APP_0309_AR.pdf

Please refer to "Exhibit A" for specific underwriting company and product form information.

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. Relationship of Payor to Primary Applicant: Self Other. If "Other" who, and reason for such: _____

5. 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 _____

6. Are all proposed Dependent Applicants (other than Spouse) between the ages of 19 and 24 full-time students? ___ Yes ___ No ___ None.
If "Yes," name of school(s) _____
If "No," who? _____ Explain _____

Is this Applicant(s) incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on the primary Applicant for support and maintenance? _____ Yes _____ No.

7. Occupation/duties of Primary Applicant: _____ Spouse Applicant: _____

8. Is any Applicant eligible for or covered under Medicare or Medicaid? ___ Yes ___ No. If "Yes," who? _____
Reason: Financial _____ Medical _____

9. a) Does any applicant currently have **health** insurance or has any applicant had health insurance within the past 12 months? ___ Yes ___ No. If "Yes," ___ Group or ___ Individual coverage? If "Yes," list applicant(s) and names of companies, certificate/policy number and types of coverage: _____

If "Yes" has coverage been in force within the past 60 days? ___ Yes ___ No. If "No", date of cancellation: _____

If "Yes", will existing **health** coverage be replaced or changed if proposed **health** coverage is issued? ___ Yes ___ No. If "No," reason: _____

9. 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

10. 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 fertility/infertility, in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage)?
___ Yes ___ No. If "Yes," who? _____ Provide Details _____
11. Does any Applicant to be insured engage in any hazardous sport or activity? (e.g.: flying, diving, skydiving, racing.) ___ Yes ___ No. If yes, is it professionally or for recreation? _____
Name: _____ Activity _____
12. During the past two years, has any person to be insured had insurance declined, postponed, had a waiver applied, or charged additional premium for life, disability or health insurance or had such insurance rescinded?
___ Yes ___ No. If "Yes," who? _____ Date: _____
Reason: _____ Company: _____
13. Name of current doctor and any other doctor or specialist seen in the past 12 months:
- a) Applicant's Doctor/Specialist _____ Phone Number (____) _____ - _____
Address _____ City _____ State _____ Zip _____
- b) Spouse's Doctor/Specialist _____ Phone Number (____) _____ - _____
Address _____ City _____ State _____ Zip _____
- c) Child(ren)'s Doctor/Specialist _____ Phone Number (____) _____ - _____
Address _____ City _____ State _____ Zip _____
14. 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: _____
15. 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: _____
16. a) When was the last time the Applicant visited a doctor/specialist/urgent care/hospital? _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
- b) When was the last time the spouse visited a doctor/specialist/urgent care/hospital? _____
Reason(s)? _____ Result(s)? _____ Recommendation(s)? _____
- c) When was the last time the child(ren) visited a doctor/specialist/urgent care/hospital?
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)? _____
17. Have you or any Applicant **EVER** had symptoms, been diagnosed, received medical advice or been treated for (if "Yes," select all applicants this applies to and show details below):

FAMILY MEMBERS

- a) **Heart or Cardiovascular Conditions/Disorders, including but not limited to:** 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?

Yes No 1 2 3 4 5 6 7 8 9 10

- b) **Endocrine Disorders, including but not limited to:** Diabetes (high blood sugar), hypoglycemia (low blood sugar), goiter, thyroid disorder, or obesity? Yes No 1 2 3 4 5 6 7 8 9 10
- c) **Blood Disorders, including but not limited to:** Blood or spleen disorder, including anemia, leukemia, high cholesterol or hyperlipidemia? Yes No 1 2 3 4 5 6 7 8 9 10
- d) **Gynecological Disorders, including but not limited to:** male or female reproductive organ disorder or disease, including breast disorder or augmentation? Yes No 1 2 3 4 5 6 7 8 9 10
- e) **Cancer / Tumor or any benign or malignant growths, including but not limited to:** Cancer, cyst, tumor, or neoplasm? Yes No 1 2 3 4 5 6 7 8 9 10
- f) **Respiratory Disorders, including but not limited to:** Respiratory disorder, including asthma, bronchitis, COPD (Chronic Obstructive Pulmonary Disease), emphysema, lung disease, sleep apnea or breathing problems? Yes No 1 2 3 4 5 6 7 8 9 10
- g) **Urinary Tract Disorders, including but not limited to:** Kidney, bladder, urinary tract, stones, or prostate disorders? Yes No 1 2 3 4 5 6 7 8 9 10
- h) **Digestive Tract Disorders, including but not limited to:** GERD, Stomach, intestines, gallbladder, liver or pancreas disorder including ulcer, colitis, crohn's disease, cirrhosis, enteritis, hepatitis, or pancreatitis? Yes No 1 2 3 4 5 6 7 8 9 10
- i) **Colon Disorders, including but not limited to:** Hernia, chronic diarrhea, bloody stool, hemorrhoids, polyps, or rectal disorders? Yes No 1 2 3 4 5 6 7 8 9 10
- j) **Eye, ear, nose, or throat disorders?** Yes No 1 2 3 4 5 6 7 8 9 10
- k) **Skin Disorders, including but not limited to:** Skin disorders, burns, lacerations, dermatitis, boils, chronic rashes, or melanoma? Yes No 1 2 3 4 5 6 7 8 9 10
- l) **Musculoskeletal Disorders, including but not limited to:** Back, shoulder, hands or feet, spine, arm or leg disorder, or arthritis, gout, bursitis, or neuritis? Yes No 1 2 3 4 5 6 7 8 9 10
- m) **Complications of Pregnancy, including but not limited to:** Cesarean section? Yes No 1 2 3 4 5 6 7 8 9 10
- n) **Brain Disorders, including but not limited to:** epilepsy, fainting spells, dizziness, seizures, paralysis, tremors, palsy, head injury, or chronic headaches? Yes No 1 2 3 4 5 6 7 8 9 10
- o) **Mental and Nervous Disorders, including but not limited to:** depression, anxiety, alcoholism, alcohol abuse, drug abuse or drug addiction? Yes No 1 2 3 4 5 6 7 8 9 10
- p) **Connective Tissue Disorders, including but not limited to:** Hodgkin's or Non-Hodgkin's Lymphoma, cystic fibrosis, collagen disease, or connective tissue disease? Yes No 1 2 3 4 5 6 7 8 9 10
- q) **Abnormal Test Results, including but not limited to:** cancer test such as a PAP Smear, mammogram, CEA (carcinoembryonic antigen), PSA (prostate specific antigen), or chest X-ray? Yes No 1 2 3 4 5 6 7 8 9 10
- r) **Symptoms of other Medical Conditions, including but not limited to:** Abnormal pain or bleeding, swollen or enlarged prostate, or night sweats? Yes No 1 2 3 4 5 6 7 8 9 10
- s) **Muscular Disorders, including but not limited to:** Any neurological disease or disorder that would include numbness of any extremity, any muscular disease or disorder, or loss of use of any limbs? Yes No 1 2 3 4 5 6 7 8 9 10
- t) **AIDS / HIV - Have you or any Applicant(s) ever been diagnosed or treated by a physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or on an AIDS-related test?** Yes No 1 2 3 4 5 6 7 8 9 10

18. Have you or any Applicant(s) WITHIN THE LAST 5 YEARS, had any other medical or surgical advice, hospitalizations, treatment, operations, or testing?

Yes No 1 2 3 4 5 6 7 8 9 10

19. In the past 3 years, have you or any applicant taken, been advised to take, or been prescribed any medication(s), including any which were not filled?

Yes No 1 2 3 4 5 6 7 8 9 10

If yes, what condition(s) is the prescribed medication(s) for?

20. Have you or any Applicant(s) been advised to have additional testing, lab work, surgical or medical treatment or had such that has not yet been completed?

Yes No 1 2 3 4 5 6 7 8 9 10

Questions 21 through 23 are ONLY required to be answered if applying for the [MEGA CRITICAL CARE/PLUS] Plan(s):

21. **Family History** - 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? If "Yes", please complete the chart below.

Yes No 1 2 3 4 5 6 7 8 9 10

FAMILY RECORD OF PROPOSED INSURED

	IMPAIRMENT	AGE AT ONSET	AGE AT DEATH
Father			
Mother			
Brothers			
Sisters			

22. **Transplant** - 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 1 2 3 4 5 6 7 8 9 10

23. **Critical Illness** - Have you or any Applicant ever consulted with or been treated by a physician 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 1 2 3 4 5 6 7 8 9 10

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

24. 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

COMPLETE THE FOLLOWING FOR ANY "YES" ANSWER TO QUESTIONS 17 THRU 20 AND ATTACH TO THE APPLICATION

Name	Nature of Illness or Accident (include symptoms, 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	

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 certificate/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
Date City

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

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 Hospital/Surgical/Medical Expense Expense
 Product Name: 25098-APP (03/09)
 Project Name/Number: 25098-APP (03/09)/25098-APP (03/09)

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 05/15/2009
Comments:
Attachments:
 AR.CLICO CH.MG-25098-APP _0309__Cert Compl Rule-Reg19.pdf
 AR.CLICO CH.MG-25098-APP _0309__flesch.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 05/15/2009
Comments:
 This submission is for a new application.

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 05/15/2009
Bypass Reason: N/A - Application only filing
Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 05/15/2009
Bypass Reason: N/A - Application only filing
Comments:

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 05/15/2009
Comments:
Attachment:
 AR.CLICO CH.MG-25098-APP _0309__Cover Letter.pdf

Satisfied -Name: Exhibit A **Review Status:** Approved-Closed 05/15/2009
Comments:

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Attachment:

CHMG-25098-APP (0309) - Exhibit A (Sample product form info).pdf

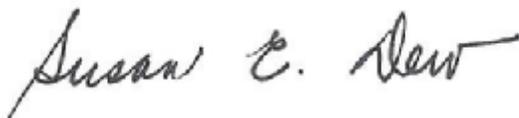
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH/MG-25098-APP (03/09) AR

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

Senior Vice President, Associate General Counsel and Chief Compliance Officer

Title

May 8, 2009

Date

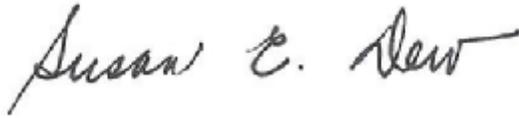
Certificate of Compliance for Arkansas

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/MG-25098-APP (03/09) AR

Flesch Reading Ease Score: 50



Susan Dew
Senior Vice President, Associate General Counsel and Chief Compliance Officer
The Chesapeake Life Insurance Company

May 8, 2009

Date



P 817-255-5487
F 817-255-8153
www.HealthMarkets.com

9151 Boulevard 26
North Richland Hills
Texas, 76180

May 8, 2009

Commissioner Jay Bradford
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-126110236

Form Number:
CH/MG-25098-APP (03/09) AR

Description:
Application for Insurance

Dear Commissioner Bradford:

The above referenced form, **CH/MG-25098-APP (03/09) AR**, is submitted for your review and approval. This form is new and not intended to replace any forms currently approved by your Department.

Upon approval, the enclosed Application form CH/MG-25098-APP (03/09) AR is intended to be used to solicit coverage with our previously approved group/individual ancillary plans underwritten by our sister company, The MEGA Life and Health Insurance Company, as well as the following individual health plans underwritten by The Chesapeake Life Insurance Company, forthcoming under separate cover:

COMPANY FORM NUMBER	DESCRIPTION
CH-26210 PPO-IP (03/09) AR	Catastrophic Expense Preferred Provider Organization (PPO) Policy
CH-26220 PPO-IP (03/09) AR	Limited Benefit Basic Medical-Surgical Expense Preferred Provider Organization (PPO) Policy

This application is concurrently being filed for review and approval under our sister company, The MEGA Life and Health Insurance Company. It is our hope that this application may also be used to solicit coverage for various group/individual health and ancillary plans that may be submitted to the Department for review and approval in the future.

It is our hope that we can use one application form for two different underwriting companies. In an effort to give you an idea of how the product forms for each underwriting company will be clearly communicated to the applicant, attached is "Exhibit A" which provides a sample of what will be input into the blank, bracketed box on the top of the first page of application form CH/MG-25098-APP (03/09) AR. Please be advised that this is not finalized, as we are waiting for the new product forms under The Chesapeake Life Insurance Company to be approved by your state (submitted under separate cover).

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 email or call collect. Your assistance in this matter is greatly appreciated.



Sincerely,

Chalon Ybarra

Chalon Ybarra
Product Compliance Analyst II
Compliance Department

HealthMarkets®

9151 Boulevard 26 • North Richland Hills • TX 76180
P (817) 255-5487 • F (817) 255-8153
chalon.ybarra@HealthMarkets.com • www.HealthMarkets.com

EXHIBIT A (continued)

Chesapeake BasicFit

Family Members 1 2 3 4 5 6 7 8 9 10

Additional Plan Option Elected

No (CH 26220-C PPO (CCHBP) (03/09)) **BFIL** Yes (CH 26220-C PPO (SSMB) (03/09)) **BFIH**

Lifetime Maximum \$500,000 \$1,000,000

Deductible: Network/Non-Network

Per Insured Person,
per Period of Treatment

All other Outpatient Covered Services, per
Insured Person, per Calendar Year

\$2,000/\$4,000

\$2,000/\$4,000

\$3,000/\$6,000

\$3,000/\$6,000

\$4,000/\$8,000

\$4,000/\$8,000

\$5,000/\$10,000

\$5,000/\$10,000

\$7,500/\$15,000

\$7,500/\$15,000

Coinsurance Network/Non-Network 80%/60% 70%/50%

Hospital Inpatient & Miscellaneous/
Inpatient Surgeon

Outpatient Surgery Facility/
Outpatient Surgeon

Option A \$15,000/\$6,000

\$7,500/\$3,000

Option B \$20,000/\$8,000

\$10,000/\$4,000

Option C \$25,000/\$10,000

\$12,500/\$5,000

Option D \$30,000/\$12,000

\$15,000/\$6,000

Option E \$35,000/\$14,000

\$17,500/\$7,000

Additional Rider

Prescription Drug Rider (CH-26222 (CCHBP/0309) or CH-26222 (SSMB/0309))

A (\$50 deductible)

B (\$250 deductible)

Optional Riders

Covered Services Extension Rider (CH-26228 (SS 03/09))

Outpatient Diagnostic Services Rider (CH-26226 (SS 03/09))

Copayment

\$100

\$250

Maximum per Calendar Year

\$2,500

\$5,000

Physician Office Services Rider (CH-26223 (SS 03/09))

2 visits

4 visits

Outpatient Accident Expense Rider (CH-26221 (SS 03/09))

Copayment/

\$50/

\$100/

\$150/

Maximum \$500

\$1,000

\$1,500

Outpatient Speech, Physical, & Occupational Therapy Rider (CH-26224 (SS 03/09)) \$50 Copayment \$100 Copayment

Continue Care Rider (CH-26225 (SS 03/09))

Rate Guarantee Rider (CH-26205 (SS 08/08))

24 months

36 months

CH/MG-25098-APP (03/09)

EXHIBIT A (continued)

Chesapeake ClassicFit

Preferred Rating

Primary

Spouse

Family Members 1 2 3 4 5 6 7 8 9 10

Additional Plan Option Elected

No (CH 26210-C PPO (CCHBP) (03/09))

CFIL

Yes (CH 26210-C PPO (SSMB) (03/09))

CFIH

Annual/Lifetime Maximum:

Option A: \$1,000,000/\$2,000,000

Option B: \$1,000,000/\$4,000,000

Option C: \$2,000,000/\$8,000,000

Deductible:

Network/Non-Network

Per Insured Person,
per Period of Treatment

\$1,000/\$2,000

\$1,500/\$3,000

\$2,500/\$5,000

\$3,500/\$7,000

\$5,000/\$10,000

\$7,500/\$15,000

All other Outpatient Covered Services, per
Insured Person, per Calendar Year

\$1,000/\$2,000

\$1,500/\$3,000

\$2,500/\$5,000

\$3,500/\$7,000

\$5,000/\$10,000

\$7,500/\$15,000

Coinsurance

Network/Non-Network

80%/60%

70%/50%

Coinsurance Maximum

Network/Non-Network

\$5,000/\$10,000

\$10,000/\$20,000

Additional Rider

Prescription Drug Expense (CH-26222 (CCHBP/0309) or (CH-26222 (SSMB/0309))

A (\$50 deductible)

B (\$250 deductible)

Optional Riders

Pregnancy/Childbirth Benefit Rider (CH-26213 (CCHBP/0309) or (CH-26213 (SSMB/0309))

Maximum

\$2,000

\$4,000

\$6,000

Outpatient Diagnostic Services Rider (CH-26226 (SS 03/09))

Copayment

\$100

\$250

Maximum per Calendar Year

\$2,500

\$5,000

\$7,500

Physician Office Services Rider (CH-26223 (SS 03/09))

2 visits

4 visits

Outpatient Accident Expense Rider (CH-26221 (SS 03/09))

Copayment

\$50

\$100

\$150

Maximum

\$500

\$1,000

\$1,500

Outpatient Speech, Physical, & Occupational Therapy Rider (CH-26224 (SS 03/09))

Continue Care Rider (CH-26225 (SS 03/09))

CHESAPEAKE ANCILLARY PLANS

Association membership is Optional

Vision (CH-26023-IP (5/07))

VSIC

Family Members 1 2 3 4 5 6 7 8 9 10

Dental (CH-26099-IP (1/08))

Family Members 1 2 3 4 5 6 7 8 9 10

Gold DTCG

Silver DTCG

Bronze DTGB

Chesapeake CancerWise (CH-26055-IP (5/07))

ECAC

Family Members 1 2 3 4 5 6 7 8 9 10

First Diagnosis Cancer Benefit Amount

\$10,000 (only available with a health plan)

\$20,000 \$30,000 \$40,000 \$50,000

CH/MG-25098-APP (03/09)

EXHIBIT A (continued)

The MEGA Life and Health Insurance Company

MEGA ANCILLARY PLANS

Association membership is Required

Income Prot. (25916-C) DSGP

- Primary \$ Elimination Period days
Spouse \$ Elimination Period days

Inc. Prot. Plus (25915-C) DIGP

- Primary Blue Collar White Collar
Indemnity Benefit \$ Waiver of Premium (25917) Return of Premium (25918)
Spouse Blue Collar White Collar
Indemnity Benefit \$ Waiver of Premium (25917) Return of Premium (25918)

MEGA Accident Advantage Plan (26038-C) ACLG

Family Members 1 2 3 4 5 6 7 8 9 10

Benefit Amount (Per insured person, per calendar year) \$

Critical Care Plus (25936-C) CI01

- Amount \$ Family Members 1 2 3 4 5 6 7 8 9 10
Amount \$ Family Members 1 2 3 4 5 6 7 8 9 10
Amount \$ Family Members 1 2 3 4 5 6 7 8 9 10

Direct Benefit Plan (25874-C) DB01

Family Members 1 2 3 4 5 6 7 8 9 10

Amount \$

Accident Catastrophic (25314-C) GA08

Family Members 1 2 3 4 5 6 7 8 9 10

Coinsurance % Deductible \$

Accident Expense Benefit (25096) Deductible \$0 \$100 Maximum \$600 \$1,200

Association membership is Optional

Vision (26023-IP (5/07)) VSIN

Family Members 1 2 3 4 5 6 7 8 9 10

Dental (26099-IP (1/08))

Family Members 1 2 3 4 5 6 7 8 9 10

- Gold DTLG Silver DTLS Bronze DTLB

MEGA CancerWise (26055-IP (5/07)) ECAN

Family Members 1 2 3 4 5 6 7 8 9 10

First Diagnosis Cancer Benefit Amount \$10,000 (only available with a health plan)

- \$20,000 \$30,000 \$40,000 \$50,000