Filing at a Glance

Company: The Mega Life and Health Insurance Company

Product Name: 25098-APP (03/09)
SERFF Tr Num: MGCC-126110237
State: ArkansasLH

TOI: H15I Individual Health - Hospital/Surgical/Medical Expense
SERFF Status: Closed
State Tr Num: 42365

Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense
Co Tr Num: CH/MG-25098-APP (03/09) AR (FOR MEGA)
State Status: Approved-Closed

Filing Type: Form
Co Status:
Reviewer(s): Rosalind Minor

Authors: Chalon Ybarra, Jaime Butler, Courtney Sharp
Disposition Date: 05/15/2009

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)
Project Number: 25098-APP (03/09)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 05/15/2009

Deemer Date:

Filing Description:

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

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 05/15/2009
Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Chalon Ybarra, Compliance Analyst II
9151 Boulevard 26
North Richland Hills, TX 76180

chalon.ybarra@healthmarkets.com
(817) 255-5487 [Phone]
(817) 255-8153[FAX]

Filing Company Information

The Mega Life and Health Insurance Company	CoCode: 97055	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: 59-2213662	

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 Mega Life and Health Insurance Company	$20.00	05/08/2009	27744977

Correspondence Summary

Dispositions

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

Disposition

Disposition Date: 05/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-126110237*	*State:*	*Arkansas*
Filing Company:	*The Mega Life and Health Insurance Company*	*State Tracking Number:*	*42365*
Company Tracking Number:	*CH/MG-25098-APP (03/09) AR (FOR MEGA)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*25098-APP (03/09)*		
Project Name/Number:	*25098-APP (03/09)/25098-APP (03/09)*		

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	List of Forms	Approved-Closed	Yes
Supporting Document	Exhibit A	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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	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 inforce? ____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 your or any applicant taken, been advised to take, or been prescribed any medication(s), including any which were not filled?
If yes, what condition(s) is the prescribed medication(s) for?

_____

☐ Yes ☐ No 1 2 3 4 5 6 7 8 9 10

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(ses), operation(s), and medication(s))	Date Started	Date Stopped	Operation	Hospitalized	Doctor's Name and Address
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐Yes ☐No	
				☐Yes ☐No	☐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 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 _____, _____
Date City 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

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 05/15/2009
Comments:
Attachments:
AR.MEGA CH.MG-25098-APP _0309__Cert Compl Rule-Reg19.pdf
AR.MEGA 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.MEGA CH.MG-25098-APP _0309__Cover Letter.pdf

Satisfied -Name: List of Forms
Review Status: Approved-Closed 05/15/2009
Comments:

SERFF Tracking Number:	*MGCC-126110237*	*State:*	*Arkansas*
Filing Company:	*The Mega Life and Health Insurance Company*	*State Tracking Number:*	*42365*
Company Tracking Number:	*CH/MG-25098-APP (03/09) AR (FOR MEGA)*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*25098-APP (03/09)*		
Project Name/Number:	*25098-APP (03/09)/25098-APP (03/09)*		

Attachment:

AR.MEGA CH.MG-25098-APP _0309__List of Forms.pdf

Review Status:

Satisfied -Name: Exhibit A

Approved-Closed 05/15/2009

Comments:

Attachment:

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

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The MEGA Life and Health 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.

Susan E. Dew

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 E. Dew

_____

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

May 8, 2009

_____

Date

HealthMarkets
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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 MEGA Life and Health Insurance Company
NAIC No. 264-97055 FEIN No. 59-2213662 SERFF Tracking # MGCC-126110237

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, as well as the following individual health plans underwritten by our sister company, 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

For the Department's review, enclosed is a "**FORMS LISTING**" showing exactly what previously approved certificate/policy forms underwritten by The MEGA Life and Health Insurance Company we intend to solicit coverage under using application form CH/MG-25098-APP (03/09) AR.

This application is concurrently being filed for review and approval under our sister company, The Chesapeake Life 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.

HealthMarkets® is the brand name for products underwritten and issued by the insurance subsidiaries of HealthMarkets, Inc. –The Chesapeake Life Insurance Company®, Mid-West National Life Insurance Company of Tennessee SM and The MEGA Life and Health Insurance Company. SM

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

HealthMarkets® is the brand name for products underwritten and issued by the insurance subsidiaries of HealthMarkets, Inc. –The Chesapeake Life Insurance Company®, Mid-West National Life Insurance Company of Tennessee SM and The MEGA Life and Health Insurance Company. SM

The MEGA Life and Health Insurance Company
FORMS LISTING

List of policy/certificate forms currently approved by Arkansas that CH/MG-25098-APP (03/09)
AR may be used to solicit coverage under:

Form Number	Deemer/Approval Date	State Tracking #
25314	08/02/1996	
25874-C	10/13/1999	
25915-C	03/30/2001	
25916-C	11/08/2000	
25936-C	12/03/2002	
26023-IP (5/07) AR	08/06/2007	35950
26038-C	04/17/2007	35598
26055-IP (5/07) AR	05/25/2007	35951
26099-IP (1/08)	02/20/2008	38184

EXHIBIT A

Applicant Name: _____ Agent Name: _____ Agent #: _____

Premium Payment Mode ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Agent	☐ Family (last 4 digits Social Security Number (SSN)) ☐☐☐☐
☐ Group 2+ (G) ☐ Association Group (I) *Will update this section with applicable options per state.*	☐ Plan Add BCN ☐☐☐☐☐☐☐☐☐☐ Network Name: _____ Network Code: _____
Agency Lead # _____ ☐ Ref. ☐ PDL	SPECIAL REQUEST(S):
BTTC: ☐ AM ☐ Afternoon ☐ PM ☐ Home ☐ Work ☐ Cell	Request for Special Effective Date (mm/dd/yyyy) ___/___/_____

The Chesapeake Life Insurance Company

Chesapeake EssentialFit Preferred Rating ☐ Primary ☐ Spouse

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

Additional Plan Option Elected

☐ No (CH 26210-PPO-C (CCHBP) 03/09) **EFIL** ☐ Yes (CH 26210-PPO-C (SSMB) 03/09) **EFIH**

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: (Per person, per calendar year) Network/Non-Network

☐ ($7,500/$15,000) ☐ ($10,000/$20,000) ☐ ($15,000/$30,000) ☐ ($20,000/$40,000)

Coinsurance: Network/Non-Network

☐ 100%/70% ☐ 90%/60% ☐ 80%/50%

Additional Riders

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

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

☑ Continued Care Rider (CH-26225 (SS 03/09))

Optional Rider

☐ Prescription Drug (CH-26214 (CCHBP/0309) or CH-26214 (SSMB/0309))

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

☐ Plan A - Visits subject to Deductible and Coinsurance

☐ Plan B - Limited Visits subject to Copayment

☐ Plan C - Unlimited Visits subject to Copayment

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 Treament	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

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	All other Outpatient Covered Services, per Insured Person, per Calendar Year
☐ $1,000/$2,000	$1,000/$2,000
☐ $1,500/$3,000	$1,500/$3,000
☐ $2,500/$5,000	$2,500/$5,000
☐ $3,500/$7,000	$3,500/$7,000
☐ $5,000/$10,000	$5,000/$10,000
☐ $7,500/$15,000	$7,500/$15,000

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

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** **DTCS** ☐ **Bronze** **DTCB**

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

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