

SERFF Tracking Number: MGCC-127687504 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 50011
Company Tracking Number: CH-26120-IP (01/12) OON AR
TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
Product Name: 2012 CLICO SR. VISION
Project Name/Number: 2012 SR. Ancillaries/CH-26120-IP (01/12)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: 2012 CLICO SR. VISION

SERFF Tr Num: MGCC-127687504 State: Arkansas

TOI: H201 Individual Health - Vision

SERFF Status: Closed-Approved-
Closed State Tr Num: 50011

Sub-TOI: H201.000 Health - Vision

Co Tr Num: CH-26120-IP (01/12) State Status: Approved-Closed
OON AR

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Lavonda English, Kim
Perkins

Disposition Date: 10/19/2011

Date Submitted: 10/12/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2012 SR. Ancillaries

Status of Filing in Domicile:

Project Number: CH-26120-IP (01/12)

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: 10/19/2011

State Status Changed: 10/19/2011

Deemer Date:

Created By: Lavonda English

Submitted By: Lavonda English

Corresponding Filing Tracking Number: MGCC-
127708031

Filing Description:

Please see attached cover letter.

Company and Contact

Filing Contact Information

LaVonda English, Senior Compliance Analyst
9151 Boulevard 26

LaVonda.English@healthmarkets.com
817-255-3155 [Phone]

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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:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	\$50.00	10/12/2011	52737690

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/19/2011	10/19/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/17/2011	10/17/2011	Lavonda English	10/19/2011	10/19/2011

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Disposition

Disposition Date: 10/19/2011

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
The Chesapeake Life Insurance Company	%	%	\$		\$	%	%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document (<i>revised</i>)	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form (<i>revised</i>)	Vision Insurance Preferred Provider Organization (PPO) Policy	Approved-Closed	Yes
Form	Vision Insurance Preferred Provider Organization (PPO) Policy	Replaced	Yes
Rate	RATES	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 10/17/2011

Submitted Date 10/17/2011

Respond By Date

Dear LaVonda English,

This will acknowledge receipt of the captioned filing.

Objection 1

- Outline of Coverage (Supporting Document)
- Vision Insurance Preferred Provider Organization (PPO) Policy , CH-26120-IP (01/12) OON AR (Form)

Comment:

It is requested that "Limited Benefit Health Insurance Coverage" be added to the face page and outlined of coverage as outlined under Rule and Regulation 18, Section 7 K.

Thank you for your cooperation in this matter.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/19/2011
 Submitted Date 10/19/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: As requested, "Limited Benefit Health Insurance Coverage" has been added to the face page and outline of coverage as outlined under Rule and Regulation 18, Section 7 K.

Related Objection 1

Applies To:

- Vision Insurance Preferred Provider Organization (PPO) Policy , CH-26120-IP (01/12) OON AR (Form)
- Outline of Coverage (Supporting Document)

Comment:

It is requested that "Limited Benefit Health Insurance Coverage" be added to the face page and outlined of coverage as outlined under Rule and Regulation 18, Section 7 K.

Thank you for your cooperation in this matter.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Outline of Coverage

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Vision Insurance Preferred Provider	CH-26120-IP		Policy/Contract/Fraternal Certificate	Initial		40.600	CH-26120-IP

<i>SERFF Tracking Number:</i>	<i>MGCC-127687504</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Chesapeake Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50011</i>
<i>Company Tracking Number:</i>	<i>CH-26120-IP (01/12) OON AR</i>		
<i>TOI:</i>	<i>H201 Individual Health - Vision</i>	<i>Sub-TOI:</i>	<i>H201.000 Health - Vision</i>
<i>Product Name:</i>	<i>2012 CLICO SR. VISION</i>		
<i>Project Name/Number:</i>	<i>2012 SR. Ancillaries/CH-26120-IP (01/12)</i>		
Organization (PPO)	(01/12)		_0112_
Policy	OON AR		OON AR.pdf

Previous Version

<i>Vision Insurance</i>	<i>CH-</i>	<i>Policy/Contract/Fraternal Initial</i>	<i>40.600</i>	<i>CH-</i>
<i>Preferred Provider</i>	<i>26120-IP</i>	<i>Certificate</i>		<i>26120-IP</i>
<i>Organization (PPO)</i>	<i>(01/12)</i>			<i>_0112_</i>
<i>Policy</i>	<i>OON AR</i>			<i>OON AR.pdf</i>

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing. Your time and attention is greatly appreciated.

Sincerely,
Kim Perkins, Lavonda English

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Form Schedule

Lead Form Number: CH-26120-IP (01/12) OON AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/19/2011	CH-26120-IP (01/12) OON AR	Policy/Cont ract/Fratern al Certificate	Vision Insurance Preferred Provider Organization (PPO) Policy	Initial		40.600	CH-26120-IP _0112_ OON AR.pdf

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: [1-800-733-1110][1-800-815-8535]

**VISION INSURANCE
PREFERRED PROVIDER ORGANIZATION (PPO) POLICY**

LIMITED BENEFIT HEALTH INSURANCE COVERAGE

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

The attached application is a part of this Policy. Please read it and check it carefully. This Policy is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

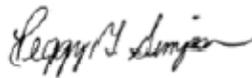
10 DAY RIGHT TO EXAMINE THE POLICY

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to Us at Our Administrative Office in North Richland Hills, Texas within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, and You will receive a full refund of all the premiums You have paid.

RENEWABILITY

This Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis.

This Policy is a legal contract between You and Us. This is a Vision Insurance Policy which provides limited benefits and is not intended to cover any medical health care expenses. **PLEASE READ YOUR POLICY CAREFULLY!**



SECRETARY



PRESIDENT

**Notice to Buyer: This Policy provides vision benefits only.
Please read it carefully.**

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POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.]

EFFECTIVE DATE OF COVERAGE: [02/15/11]

COVERED DEPENDENTS:

EFFECTIVE DATE OF COVERAGE:

[No Dependent Coverage]

[Johnette Doe]

[02/15/11]

[John Doe, Jr.]

[02/15/11]

[Johnita Doe]

[03/31/12]

POLICY NUMBER: [ABC1234567]

POLICY DATE: [02/15/11]

INITIAL PREMIUM: \$[0.00]

MODE OF PAYMENT: [Monthly]

SCHEDULE OF BENEFITS

Deductible (per Insured Person, per calendar year):

[0][10][20][30]

BENEFITS

BENEFIT PAYMENT RATE

NETWORK PROVIDER

NON-NETWORK PROVIDER*

Comprehensive Eye Examination

[100%]

[75%]

(Limited to [one] Comprehensive Eye Examination every [12] months from last date of service, per Insured Person.)

Corrective Spectacle Lenses

(standard, uncoated plastic lenses)

(In lieu of corrective contact lenses; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[0][5][10][15]

Single Vision Lenses

[100%]

[75%]

Bifocal Lenses

[100%]

[75%]

Trifocal Lenses

[100%]

[75%]

Frames

[100% up to [\$100][120]]

[100% up to [\$75][90]]

(In lieu of corrective contact lenses; limited to [one] purchase every [12] [24] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[0][5][10][15]

POLICY SCHEDULE
SCHEDULE OF BENEFITS (continued)

BENEFITS

BENEFIT PAYMENT RATE

NETWORK PROVIDER

NON-NETWORK PROVIDER*

Corrective Contact Lenses

(In lieu of Corrective Spectacle Lenses and Frames; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):
 [\$0][\$5][\$10][\$15]

Non-disposable
 Disposable
 Therapeutic

[100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]

Contact Lens Fitting

[Not Covered]

[Not Covered]

Follow-Up Visits

[Not Covered]

[Not Covered]

***For Covered Expenses obtained through a Non-Network Provider,
 Please use the following contact information:**

EyeMed Visioncare, LLC
Administrative Office: 4000 Luxottica Place
Mason, Ohio 45040

DEFINITIONS

Benefit Payment Rate means the maximum amount of Covered Expenses which will be considered for each occurrence of a service or purchase of a supply. [Any Deductible or Copayment Amounts will be applied first and then the Benefit Payment Rate will be applied.]

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Policy unless rates are changed on all Policies issued on the same Class Basis.

Comprehensive Eye Examination means a general evaluation of the complete visual system, including the review of an Insured Person's history, conducting a general medical observation, an external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examinations, and initiation of diagnostic and treatment programs for the Insured Person. It may also include biomicroscopy, examination with cycloplegia, or mydriasis and tonometry. The comprehensive services constitute a single service entity, but need not be performed at one session. Follow-up examinations are not considered Comprehensive Eye Examinations by this definition.

Copayment means the specific dollar amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward Deductibles, if any.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Policy and has not terminated.

Covered Expenses means the charge for services and supplies listed in the POLICY SCHEDULE.

Deductible means the amount that must be paid each calendar year by any or all Insured Persons before Benefits will be paid. The Deductible amount will be applied first, and then the Copayment, if any and Benefit Payment Rate will be applied.

Effective Date of Coverage means the date coverage becomes effective under this Policy with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your natural and adopted children and step-children who are under [26] years of age (the Limiting Age).

Immediate Family means the spouse, parent, son, daughter, brother or sister of the Insured Person.

Insured Person means You or a Covered Dependent under this Policy.

Network Provider (or Preferred Provider Organization (PPO)) means an Optometrist, Ophthalmologist, Optician or Optical Supply Business that has contracted with [EyeMed Visioncare, LLC] and has agreed to provide vision care services and supplies as described by that contract to Insured Persons under this Policy. A list of the Network Providers in the network associated with this Policy is available to You at [www.eyemedvisioncare.com].

Non-Network Provider (or Non-Preferred Provider Organization (Non-PPO)) means an optometrist, ophthalmologist, optician or optical supply business that has NOT entered into a contractual agreement with [EyeMed Visioncare, LLC] or is not a participating provider at the time services are rendered to provide vision care services or supplies to Insured Persons at discounted rates.

Ophthalmologist means a physician who specializes in the medical and surgical care of the eyes and visual system as well as in the prevention of eye disease and injury. They provide a full spectrum of care including routine eye exams, diagnosis and medical treatment of eye disorders, and prescriptions for corrective optical lenses.

Optical Dispensary means an establishment licensed and authorized to prescribe and/or dispense corrective optical lenses.

Optician means one who only makes and dispenses eyeglasses and other eye corrections for optical devices.

Optometrist means a physician of optometry who provides routine vision care services and is authorized to prescribe corrective optical lenses.

Policy means this written description of coverage provided by Us to You.

We, Us and Our means The Chesapeake Life Insurance Company.

You, Your, Yours means the primary insured named in the POLICY SCHEDULE whose coverage has become effective and has not terminated.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

Additional Dependents

You may add Eligible Dependents by providing evidence of insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent and the Effective Date of Coverage for such Eligible Dependent will be shown by endorsement.

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31-day grace period, We may cancel this Policy without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period unless and until the premium due is received during the grace period.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under this Policy at any time and from time to time, provided, We have given You written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Unearned Premiums Refund

Upon the death of an Insured Person, the proceeds payable to the Insured Person or his/her estate shall include premiums paid for insurance coverage for the period beyond the end of the month in which the death occurred. Unearned Premiums shall be paid in a lump sum payment no later than thirty (30) days after the proof of the Insured Person's death has been furnished to Us.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no benefits will be payable under this Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Policy on:

1. The date Your coverage terminates, except as provided in the SPECIAL CONTINUATION FOR DEPENDENTS provision in the Policy;
2. The date such dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Upon your death or divorce, Your Covered Dependent spouse, and Your Covered Dependent child(ren) who is/are under the Limiting Age, may continue their same coverage under this Policy without evidence of insurability.

To continue coverage, Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate, and pay any required premium.

Reinstatement

If coverage under this Policy terminates due to non-payment of premium (subject to the Grace Period), We require an application for reinstatement. The reinstatement will not become effective unless We approved such application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Policy or by issuing You a new Policy.

BENEFITS

Benefits are payable under this Policy for the following Covered Expenses. Unless otherwise stated herein, all Covered Expenses are subject to:

1. [The [Deductible] [and] [Copayment] shown in the POLICY SCHEDULE (if any);]
2. The Schedule of Benefits shown on the POLICY SCHEDULE;
3. The EXCLUSIONS AND LIMITATIONS; and
4. All other provisions of this Policy.

COVERED EXPENSES

Covered Expenses are fees associated with the services and supplies covered under this Policy which are incurred by an Insured Person and not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Covered Expenses must be incurred while this coverage is in force.

Comprehensive Eye Examinations

Covered Expenses include [one] Comprehensive Eye Examination every [12] months from last date of service for each Insured Person. Covered Expenses include:

1. Consultation with Insured Person to determine their chief complaint, personal ocular disease history, occupation, lifestyle, use of vision, glasses or contact lenses, general medical history (including medications), environmental or medication allergies, family's general and ocular history, final assessment of Insured Person, management plan for Insured Person and any professionally-required reports.
2. General observation of Insured Person to assess their neurological orientation (time/place/person) and psychiatric mood and affect (depression/anxiety/agitation);
3. Clinical and diagnostic testing and evaluation related to:
 - a. the inspection of conjunctiva and sclera;
 - b. examination of pupils, orbits, ocular adnexa (including lids, lacrimal glands, lacrimal drainage, and orbits),
 - c. testing of visual acuity (not including determination of refractive error), color vision, and stereopsis;
 - d. gross visual field testing (confrontation);
 - e. basic ocular motility;
 - f. measurement of intraocular pressure;
 - g. examination of the vitreous with pupillary dilation (unless contraindicated);
 - h. ophthalmoscopic examination of optic disc(s) and posterior segment through undilated and/or dilated (unless contraindicated) pupils;
 - i. ophthalmoscopic examination of the macula, retinal periphery and/or retinal vessels with pupillary dilation (unless contraindicated);
 - j. slit lamp examination of irides, cornea(s), crystalline lenses and anterior chambers (may be completed with other instrumentation due to Insured Person's age and/or location of exam).
4. Refraction, including objective (retinoscopy or auto-refraction), subjective, and corrected visual acuities (distance and near);

Covered Expenses do not include contact lens fittings or follow-up visits.

Corrective Spectacle Lenses

Covered Expenses include [one] purchase of standard, uncoated plastic lenses every [12] months from last date of service for each Insured Person. Benefit includes single vision, bifocal and trifocal lenses. Benefit is in lieu of Corrective Contact Lenses.

Frames

Covered Expenses include [one] purchase of frames for corrective spectacle lenses every [12] [24] months from the last date of service for each Insured Person. Benefit is in lieu of Corrective Contact Lenses.

Corrective Contact Lenses

Covered Expenses include [one] purchase of contact lenses every [12] months from last date of service for each Insured Person. Benefit is in lieu of Corrective Spectacle Lenses and Frames, and includes non-disposable, disposable and therapeutic contact lenses. Benefit does not include contact lens fittings.

NETWORK AND NON-NETWORK PROVIDER SERVICES

Network Provider services and supplies are available to all Insured Persons through any participating Network Provider. The Network Provider's toll-free telephone number and website as shown on the identification card provides Insured Persons with a means to locate a Network Provider within the Insured Persons geographic area.

1. Services or supplies obtained through a Network Provider will be subject to the Network Provider Benefit Payment Rate shown in the POLICY SCHEDULE.
2. Services or supplies obtained through a Non-Network Provider will be subject to the Non-Network Provider Benefit Payment Rate shown in the POLICY SCHEDULE.

EXCLUSIONS AND LIMITATIONS

Benefits will not be provided under this Policy for expenses associated with the following:

1. Orthoptic or vision training and any associated supplemental testing;
2. Plano lenses;
3. Lens coating;
4. Two pair of glasses, in lieu of bifocals or trifocals;
5. Medical or surgical treatment of the eyes;
6. [Any type of corrective vision surgery, including LASIK surgery];
7. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
8. Any services or supplies when paid under any Worker's Compensation or similar law;
9. No-line bifocal or progressive lenses;
10. Photochromic, transition, or polycarbonate lenses;
11. Lenticular lenses;
12. Sub-normal vision aids or non-prescription lenses;
13. Services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
14. Eyeglasses when the change in prescription is less than .5 Diopter;
15. Experimental or investigational or non-conventional treatment or device;
16. Eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting, edge polishing
17. Oversized lenses;
18. High index lenses of any material type;
19. Fitting for contact lenses;
20. Follow-up visits; or
21. Charges incurred after this Policy has terminated or coverage has ended.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. The Policy;
2. Any applications for the proposed insured individuals; and
3. Any endorsements, amendments or riders attached.

All statements made by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment approved and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to [Our administrator, EyeMed Visioncare, LLC 4000 Luxottica Place Mason, Ohio 45040,] within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all Benefits due under the Policy promptly upon receipt of due Proof of Loss.

All Benefits are payable to You, however, at Our option, We may pay the provider of service instead, unless You have requested otherwise in writing prior to providing proof of loss. If any such Benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any Benefit, We may, at Our option, pay such Benefit to Your estate or any one or more of the following relatives: Your spouse; mother, father, child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Legal Action

No action at law or in equity will be brought to recover on this Policy prior to the expiration of 60 days after Proof of Loss has been filed as required under this Policy, or will any action be brought after expiration of 3 years (36 months) after the time written Proof of Loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due to Us because of past underpayment, will be made so that We receive the premiums due at the correct age.

Incontestability

After 2 years (24 months) from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the Application will be used to void the coverage, or deny a claim, unless the loss was incurred during the first 2 years following such Insured Person's Effective Date of Coverage.

Conformity

Any provision of this Policy which, on the Effective Date of Coverage, is in conflict with the statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

Change of Residence

If You move, You must notify the Company.

SERFF Tracking Number: MGCC-127687504
 Filing Company: The Chesapeake Life Insurance Company
 Company Tracking Number: CH-26120-IP (01/12) OON AR
 TOI: H201 Individual Health - Vision
 Product Name: 2012 CLICO SR. VISION
 Project Name/Number: 2012 SR. Ancillaries/CH-26120-IP (01/12)

State: Arkansas
 State Tracking Number: 50011
 Sub-TOI: H201.000 Health - Vision

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
The Chesapeake Life Insurance Company	%	%				%	%

SERFF Tracking Number: MGCC-127687504 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 50011
 Company Tracking Number: CH-26120-IP (01/12) OON AR
 TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
 Product Name: 2012 CLICO SR. VISION
 Project Name/Number: 2012 SR. Ancillaries/CH-26120-IP (01/12)

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/19/2011	RATES	CH-26120-IP (01/12) AR	New		CH-26120-IP (0112) OON AR Rates 20111005.pdf

The Chesapeake Life Insurance Company

Administrative Office: P.O. Box 982010, North Richland Hills, TX 76182-8010

Vision Insurance Preferred Provider Organization (PPO) Policy

CH-26120-IP (01/12) OON AR

Issue Age Rates

Age*	<u>Monthly Premium Rate</u>	
	0-64	65+
Individual	\$9.00	\$10.00
2 Person	\$16.00	\$18.00
Family	\$25.00	\$28.00

*Age of primary insured

Above rates are for \$0 Calendar Year Deductible

Multiply the monthly rate by 3 for quarterly rates, 6 for semi-annual, and 12 for annual premium rates

A billing fee of up to \$5 may be charged on direct bill modes

A one-time application fee of up to \$30 may be applicable

SERFF Tracking Number: MGCC-127687504 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 50011
 Company Tracking Number: CH-26120-IP (01/12) OON AR
 TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
 Product Name: 2012 CLICO SR. VISION
 Project Name/Number: 2012 SR. Ancillaries/CH-26120-IP (01/12)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/19/2011
Comments:		
Attachments:		
AR -26120_0112_ READ.pdf		
Arkansas Rule and Regulation 19 26120_0112_.pdf		
ARGA 0104.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	10/19/2011
Comments:		
We intend to use either previously approved application form CH-26109-APP (04/11), that was approved by your department on June 23, 2011 under SERFF filing# MGCC-127174546, to solicit this coverage to non-Medicare eligible applicants, or application form CH-26109-APP SRM D/V (01/12), which was submitted to your department under separate cover on October 12, 2011 under SERFF filing# MGCC-127708031, when this product is marketed to Medicare eligible applicants.		
Attachments:		
CH-26109-APP SRM DV _0112_.pdf		
CH-26109-APP _0411_.pdf		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	10/19/2011
Comments:		
Attachment:		
CH-26120-IP (0112) OON AR Act Memo 20111005.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	10/19/2011
Comments:		

SERFF Tracking Number: MGCC-127687504 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 50011
Company Tracking Number: CH-26120-IP (01/12) OON AR
TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
Product Name: 2012 CLICO SR. VISION
Project Name/Number: 2012 SR. Ancillaries/CH-26120-IP (01/12)

Attachment:

CH-26120-IP OC _0112_ OON AR.pdf

Satisfied - Item: Cover letter

Comments:

Attachment:

LTR CH-26120-IP _0112_ AR.pdf

Item Status:

Approved-Closed

Status

Date:

10/19/2011

FLESCH READABILITY CERTIFICATE

Policy or Rider
Form Number

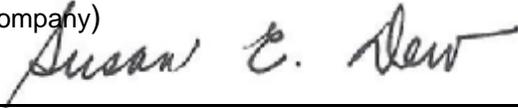
Flesch Score

CH-26120-IP (01/12) OON AR
CH-26120-IP OC (01/12) OON AR

40.6
40.6

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility and format requirements of any applicable laws and regulations in the state of Arkansas.

The Chesapeake Life Insurance Company
(Company)



(Signature)

Susan E. Dew
(Printed Name)

SVP, Associate General Counsel & Chief Compliance Officer
(Title / Department)

October 12, 2011
(Date)

Arkansas Rule and Regulation 19

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

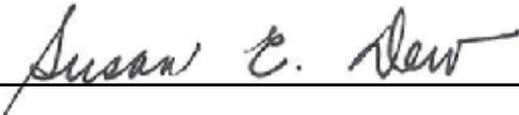
CH-26120-IP (01/12) OON AR

CH-26120-IP OC (01/12) OON AR

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

The Chesapeake Life Insurance Company

(Company)



(Signature)

Susan E. Dew

(Printed Name)

SVP, Associate General Counsel & Chief Compliance Officer

(Title / Department)

October 12, 2011

(Date)

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

**The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201**

**Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904**

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.]



APPLICATION FOR POLICIES UNDERWRITTEN BY THE CHESAPEAKE LIFE INSURANCE COMPANY

Does Applicant have existing vision or dental insurance currently in force? Yes No

If "Yes," indicate Applicant(s): 1 2

Will the proposed vision or dental insurance replace any existing insurance in force? Yes No

If "Yes," indicate Applicant(s): 1 2, and give type of contract or policy number and name of Company: _____

Is Applicant Eligible for Medicare? Yes No

If "Yes," indicate Applicant(s): 1 2, and please complete the following:

- I have received and understand the Important Notice to Persons on Medicare.
 I have agreed to accept a link to the Medicare Buyers Guide on the Company website at www.[_____] ; or
 I have received a hardcopy of the Medicare Buyers Guide.

SECTION [3] - BILLING INFORMATION

Initial Payment: Bank Draft (Auth Required) Credit Card Direct Pay (Check)
Future Payment Method: Bank Draft (Auth Required) Credit Card Direct Bill

Billing / Mode: Monthly Bank Draft (Auth Required) Quarterly Semi-Annually Annually
Requested Effective Date of Coverage (if other than issue date): _____
Special Request(s): _____

For Office Use Only
Premium Amount quoted [(including \$[20] one-time application fee)]: \$ _____ [Check #: _____ (if collected at sale)]

SECTION [4] - ACKNOWLEDGEMENTS, 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; (d) no insurance will take effect unless and until the initial premium has been paid in full and/or honored by my financial institution, the Application is approved by the Company and the Policy is issued and delivered to the Applicant during his/her lifetime.

I have received and understand the Description of Information Practices, Notice Concerning the Medical Information Bureau, Notification of Consumer Report and other consumer reports.

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

Signed _____ / _____ / _____ at _____ City _____ State _____

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

TO BE ANSWERED BY AGENT (If Applicable):

- Each question on this application was answered and documented by the Applicant(s) named above; OR
 I, the Agent, certify that each question on this application was asked by me of the Applicant(s) named above, and all answers were accurately documented.

X _____ Signature of Licensed Agent
Print Full Name _____ Agent Number _____



**APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY**

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

New Applicant Re-apply

Primary Applicant Name: _____ Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number: (____) _____

Best Time to Call: AM PM Home Work Cell

Email Address: _____

Marital Status: Single Married Common Law

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: ____ / ____ / ____

SCHEDULE OF APPLICANTS								
Please Print (Full Name)	Sex	Relationship	DOB	Please check below for any Dependent Applicant age [26] or over (other than spouse) who is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the primary Applicant for support and maintenance	Ht.	Wt.	Tobacco or Nicotine substitute use in last 12 months?	Social Security #
(1)		Primary		N/A			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(2)		Spouse		N/A			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(3)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(4)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(5)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(6)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(7)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	
(8)				<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO	



APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Vision Plan VSC1 (Vision Insurance Policy Form CH-26023-IP (5/07), or its state variation): Applicant(s): 1 2 3 4 5 6 7 8]

[Premiere Vision Plan VSP1 (Vision Insurance Policy Form CH-26120-IP (04/11), or its state variation):
Applicant(s): 1 2 3 4 5 6 7 8]

[Dental Plan (Dental Insurance Policy Form CH-26099-IP (1/08), or its state variation): Applicant(s): 1 2 3 4 5 6 7 8
 Gold DCG1 Silver DCS1 Bronze DCB1]

[PPO Dental Plan (Dental Insurance Policy Form CH-26121-IP (04/11), or its state variation):
 Basic DPB1 Premiere DPP1 Applicant(s): 1 2 3 4 5 6 7 8]

[Accident Direct Bundle ADBC Applicant(s): 1 2 3 4 5 6 7 8
[Hospital Confinement Direct] (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):
 \$[250] Daily Benefit Amount
[Accident Direct] (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):
 \$[10,000] Maximum Accidental Injury Benefit Amount
[Accident Disability Direct] Applicant(s): 1 2
(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):
 \$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration

[Complete Direct Bundle KDBC Applicant(s): 1 2 3 4 5 6 7 8
[Hospital Confinement Direct] (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):
 \$[250] Daily Benefit Amount
[Accident Direct] (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):
 \$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):
 \$[5,000] Lifetime Maximum Benefit Amount
[Income Protection Direct] Applicant(s): 1 2
(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):
 \$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [24 Month] Duration

[Hospital Direct Bundle SDBC Applicant(s): 1 2 3 4 5 6 7 8
[Hospital Confinement Direct] (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):
 \$[250] Daily Benefit Amount
[Accident Direct] (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):
 \$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):
 \$[5,000] Lifetime Maximum Benefit Amount]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[ProtectFit Plus Plan (Accidental Injury Only Insurance Policy Form CH-26110-IP (06/09), or its state variation):

High Option FPRH] Low Option FPRL]

Applicant(s): 1 2 3 4 5 6 7 8]

[HospitalFit Plus Plan (Hospital and Surgical Indemnity Policy Form CH-26111-IP (06/09), or its state variation):

High Option FPIH] Low Option FPIL]

Applicant(s): 1 2 3 4 5 6 7 8]

[PersonalFit Plus Plan (Sickness-only Scheduled Indemnity Policy Form CH-26112-IP (06/09), or its state variation):

High Option FPEH] Low Option FPFL]

Applicant(s): 1 2 3 4 5 6 7 8]

[[CancerWise ECA1 (Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation):

Applicant(s): 1 2 3 4 5 6 7 8

First Diagnosis Cancer Benefit Amount: \$20,000] \$30,000] \$40,000] \$50,000]]

[Critical Illness Direct CIIC (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]
 \$50,000] \$60,000] \$70,000] \$80,000] \$90,000] \$100,000]

Applicant 1

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]
 \$50,000] \$60,000] \$70,000] \$80,000] \$90,000] \$100,000]

Applicant 2

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]
 \$50,000] \$60,000] \$70,000] \$80,000] \$90,000] \$100,000]

Applicant(s): 3 4 5 6 7 8

[Critical Accident Direct CAIC (Critical Accidental Injury Policy Form CH-26123-IP (04/11), or its state variation):

Lifetime Maximum Benefit Amount:

\$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]
 \$50,000] \$60,000]

Applicant 1

Lifetime Maximum Benefit Amount:

\$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]
 \$50,000] \$60,000]

Applicant 2

Lifetime Maximum Benefit Amount:

\$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]
 \$50,000] \$60,000]

Applicant(s): 3 4 5 6 7 8



APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Accident Disability Direct DSIC (Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 1
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 2
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months]

[Income Protection Direct DIIC (Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 1
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months

Monthly Indemnity Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 Applicant 2
Elimination Period: 14 Days 30 Days
Duration: 6 Months 12 Months 18 Months 24 Months]

[Hospital Confinement Direct DBIC (Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):

Daily Benefit Amount: \$250 \$500 \$750 \$1,000 Applicant(s): 1 2 3 4 5 6 7 8]

[Accident Direct ACLC (Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):

Maximum Accidental Injury Benefit Amount: Applicant(s): 1 2 3 4 5 6 7 8
 \$5,000 \$10,000 \$15,000 \$20,000 \$25,000]

[Accident Companion AGLC (Accidental Injury Only Insurance Policy Form CH-26122-IP (01/11), or its state variation):

Level \$2,500 Level \$5,000 Level \$7,500 Level \$10,000 Applicant(s): 1 2 3 4 5 6 7 8]



If applying for [VISION PLAN] and/or [DENTAL PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 2 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT COMPANION]
[♦ ACCIDENT DIRECT]
[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ACCIDENT DIRECT]

[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PROTECTFIT PLUS]

1. Does any Applicant currently or in the future plan to participate in any volunteer police or firefighting activities; plan to participate in mountaineering using ropes and/or any other equipment; parachuting/skydiving; base jumping; heli-snowboarding; heli-skiing; hang gliding; plan to participate in any hazardous sport or activity; or plan to race any type of vehicle in an organized event? Yes No

If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

[SECTION 3 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT COMPANION]
[♦ ACCIDENT DIRECT]
[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ CANCERWISE]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ACCIDENT DIRECT]

[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]
[♦ PROTECTFIT PLUS]

2. Is any Applicant eligible for or covered under Medicare or Medicaid? Yes No
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
3. (a) Occupation/duties of Primary Applicant: _____ Blue Collar White Collar
(Complete if applying for Spouse)
(b) Occupation/duties of Spouse Applicant: _____ Blue Collar White Collar
4. Has any Applicant been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or an AIDS-related test? Yes No
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
5. Within the past 60 days has any Applicant had or been advised by a Physician to have any testing or any treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? Yes No
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8



If applying for [ACCIDENT COMPANION,] [ACCIDENT DIRECT BUNDLE,] [COMPLETE DIRECT BUNDLE,] [HOSPITAL DIRECT BUNDLE,] [PROTECTFIT PLUS PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 4 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT]

[♦ ACCIDENT DISABILITY DIRECT]

[♦ CRITICAL ACCIDENT DIRECT]

6. Has any Applicant had symptoms that resulted in a diagnosis or treatment (including medication) for **any** of the following: Stroke, Multiple Sclerosis, Huntington's disease, Muscular Dystrophy, Guillain-Barre syndrome, Epilepsy, seizures, paralysis, Parkinson's, Cerebral Palsy, or Alzheimer's, in the last 12 months?
If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8 Yes No



If applying for [ACCIDENT DIRECT PLAN,] [CRITICAL ACCIDENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 5 -] APPLICABLE TO THE FOLLOWING PLAN ONLY:

[♦ CANCERWISE]

[♦ CRITICAL ILLNESS DIRECT]

Family History:

7. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had any form of cancer (other than skin cancer) prior to age 65? Yes No
If any "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
8. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Senile Dementia prior to age 65? Yes No
If any "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

[SECTION 6 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ **CANCERWISE**]
[♦ **CRITICAL ILLNESS DIRECT**]
[♦ **HOSPITAL CONFINEMENT DIRECT**]

[♦ **HOSPITALFIT PLUS**]
[♦ **INCOME PROTECTION DIRECT**]
[♦ **PERSONALFIT PLUS**]

9. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized, treated, or been treated for any of the following:
- (a) 2 or more occurrences of Skin Cancer other than melanoma, within last 12 months? Yes No
 - (b) recurrent breast tumors, polycystic disease, non-malignant growths/tumors, or neoplasms, within the last 3 years? Yes No
 - (c) melanoma, breast cancer, prostate cancer, colon cancer, Hodgkin's Disease, non-Hodgkin's Lymphoma, leukemia, or other malignant growths or tumors (*excluding conditions listed in 9 (a) or 9 (b)*), within the last 10 years? Yes No
- If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
10. Within the last two years, has any Applicant been advised of any abnormal diagnostic test results for pelvic exam/pap smear, mammogram, prostate/PSA exam or colorectal cancer screening that were not later confirmed as normal (i.e., a false positive test), or been advised to have any diagnostic testing which has not yet been completed? Yes No
- If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8
11. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for: emphysema, hemochromatosis, ulcerative colitis or Crohn's, cirrhosis, hepatitis (excluding type A), COPD (chronic obstructive pulmonary disorder), within the last 10 years? Yes No
- If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8



If applying for [CANCERWISE] ONLY, please proceed to [SECTION 9].

[SECTION 7 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

**[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]**

**[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]**

12. Is any Applicant currently confined in a hospital or nursing home, or has any Applicant received medical advice or treatment for Alzheimer's Disease or Senile Dementia, or does any Applicant require human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? Yes No

If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

13. Is any proposed female Applicant now pregnant, or being tested for or receiving treatment for fertility/infertility? Yes No

If "Yes," indicate Applicant(s): 1 2 3 4 5 6 7 8

14. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for **any** of the following:

(a) Cholesterol/Blood Pressure: Uncontrolled hyperlipidemia (an LDL cholesterol reading of 150 or greater or a triglycerides reading of 325 or greater), uncontrolled hypertension (a Systolic reading of 150 or greater or Diastolic reading of 95 or greater), within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(e) Endocrine System: Diabetes (type I or II), within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		(f) Connective Tissue Disease or Disorder: Systemic Lupus (SLE) or sarcoidosis, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Mental Diseases or Disorders: Bipolar disorder, Schizophrenia, major depressive disorder, manic disorder, alcoholism, alcohol abuse, drug abuse or drug addiction, within the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(g) Respiratory System: Lung disease or Cystic Fibrosis, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Heart and Circulatory System: Heart disorder or disease, blood clots, blood vessel blockages, myocardial infarction (heart attack), stroke, mini-stroke (including transient ischemic attack), any form of heart surgery, or aneurysms, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(h) Nervous System: Multiple Sclerosis, Huntington's disease, Muscular Dystrophy, Guillain-Barre syndrome, Epilepsy, seizures, paralysis, or traumatic brain injury, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Renal System: Abnormal kidney functions (excludes kidney stones), chronic renal failure, or End Stage Renal Disease, within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(i) Fainting, dizziness, chronic headaches, sudden vision deterioration, loss of depth perception, sudden hearing loss, or loss of balance control, any of which were unexplained and occurred within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to any of the above, indicate Applicant(s): 1 2 3 4 5 6 7 8



If applying for [HOSPITALFIT PLUS,] [PERSONALFIT PLUS,] [CRITICAL ILLNESS DIRECT,] [HOSPITAL CONFINEMENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 8 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DISABILITY DIRECT]

[♦ INCOME PROTECTION DIRECT]

15. Has any Applicant ever been convicted of any felony activity? Yes No
If "Yes," indicate Applicant(s): 1 2
16. (a) Within the last 12 months, has the Primary Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? Yes No
(Complete if applying for Spouse)
(b) Within the last 12 months, has the Spouse Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? Yes No
17. (a) Does the Primary Applicant work less than 25 hours per week in the occupation/duties previously listed? Yes No
(Complete if applying for Spouse)
(b) Does the Spouse Applicant work less than 25 hours per week in the occupation/duties previously listed? Yes No
18. (a) What is the Primary Applicant's annual gross income from the occupation/duties previously listed? \$ _____
(Complete if applying for Spouse)
(b) What is the Spouse Applicant's annual gross income from the occupation/duties previously listed? \$ _____
19. In the last five years has any Applicant been hospitalized or had surgery for spine, neck or back, or surgical joint repair or replacement? Yes No
20. Within the last 6 months has any Applicant received treatment (excluding chiropractic treatments or physical therapy, less than once per month) or has any Applicant taken prescription medication for conditions/disorders related to the spine, neck or back, or joints (shoulders, knees, hips or ankles)? Yes No
21. Has any Applicant currently or within the last 5 years filed a claim or received benefits from any disability insurance or salary continuation plan for disability (other than pregnancy)? Yes No
22. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for sleep apnea, fibromyalgia, Parkinson's, chronic fatigue syndrome, unresolved carpal tunnel syndrome, rheumatoid arthritis, or Epstein Barr, within the last 12 months? Yes No

If any "Yes" to questions 19 - 22, indicate Applicant(s): 1 2



Please proceed to [SECTION 9].

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: [1-800-733-1110][1-800-815-8535]

VISION INSURANCE

**PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
OUTLINE OF COVERAGE FOR FORM: CH-26120-IP (01/12) OON AR**

LIMITED BENEFIT HEALTH INSURANCE COVERAGE

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to health Insurance for People With Medicare available from the Company.

- 1. **READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. **VISION INSURANCE POLICY** – The Policy is designed to provide You or Your Covered Dependents with coverage when certain losses are incurred for vision services and supplies. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the EXCLUSIONS & LIMITATIONS section.
- 3. **BENEFITS** – While the Policy is in force, Covered Expenses include the fees associated with the Vision Care services and supplies shown below when provided by an authorized provider (i.e., ophthalmologist, optometrist, or optical dispensary). Payment of benefits for any such service or supply will be made in accordance with the specified Benefit Payment Rate [and any [Deductible] [and] [Copayment] Amounts] shown below. The Benefit Payment Rate is the maximum amount of Covered Expenses We will pay for each occurrence or purchase of a supply or service. [Any Deductible Amounts and/or Copayments will be applied first and then the Benefit Payment Rate will be applied.]

Deductible (per Insured Person, per calendar year):	[\$0][\$10][\$20][\$30]
---	-------------------------

BENEFITS

BENEFIT PAYMENT RATE

NETWORK PROVIDER

NON-NETWORK PROVIDER

Comprehensive Eye Examination

[100%]

[75%]

(Limited to [one] Comprehensive Eye Examination every [12] months from last date of service, per Insured Person.)

Corrective Spectacle Lenses

(standard, uncoated plastic lenses)

(In lieu of corrective contact lenses; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[\$0][\$5][\$10][\$15]

Single Vision Lenses

[100%]

[75%]

Bifocal Lenses

[100%]

[75%]

Trifocal Lenses

[100%]

[75%]

BENEFITS**BENEFIT PAYMENT RATE****NETWORK PROVIDER****NON-NETWORK PROVIDER****Frames**

[100% up to [\$100][\$120]]

[100% up to [\$75][\$90]]

(In lieu of corrective contact lenses; limited to [one] purchase every [12] [24] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[\$0][\$5][\$10][\$15]

Corrective Contact Lenses

(In lieu of Corrective Spectacle Lenses and Frames; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[\$0][\$5][\$10][\$15]

Non-disposable

[100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]

Disposable

[100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]

Therapeutic

[100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]

Contact Lens Fitting

[Not Covered]

[Not Covered]

Follow-Up Visits

[Not Covered]

[Not Covered]

4. EXCLUSIONS & LIMITATIONS – Benefits will not be provided under the Policy for expenses associated with the following:

1. Orthoptic or vision training and any associated supplemental testing;
2. Plano lenses;
3. Lens coating;
4. Two pair of glasses, in lieu of bifocals or trifocals;
5. Medical or surgical treatment of the eyes;
6. [Any type of corrective vision surgery, including LASIK surgery];
7. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
8. Any services or supplies when paid under any Worker's Compensation or similar law;
9. No-line bifocal or progressive lenses;
10. Photo-chromic, transition, or polycarbonate lenses;
11. Lenticular lenses;
12. Sub-normal vision aids or non-prescription lenses;
13. Services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
14. Eyeglasses when the change in prescription is less than .5 Diopter;
15. Experimental or investigational or non-conventional treatment or device;
16. Eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting, or edge polishing;
17. Oversized lenses;
18. High index lenses of any material type;
19. Fitting for contact lenses;
20. Follow-up visits; or
21. Charges incurred after the Policy has terminated or coverage has ended.

5. RENEWABILITY – The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis.

6. BEGINNING OF COVERAGE - We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

7. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates, except as provided under the SPECIAL CONTINUATION FOR DEPENDENTS provision;
2. The date such dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof, We may terminate the coverage of such person after the attainment of the Limiting Age.

8. PREMIUMS – We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Premium Due (at time of application) \$ _____



**The Chesapeake
Life Insurance Company**
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

October 12, 2011

Commissioner Jay Bradford
Arkansas Department of Insurance
Life and Health Division
1200 W 3Rd ST
Little Rock, AR 72201-1904

RE: THE CHESAPEAKE LIFE INSURANCE COMPANY
NAIC#: 264-61832 FEIN#: 52-0676509

<u>Form Number</u>	<u>DESCRIPTION</u>
CH-26120-IP (01/12) OON AR	Vision Insurance Preferred Provider Organization (PPO) Policy
CH-26120-IP OC (01/12) OON AR	Outline of Coverage

Dear Commissioner Bradford:

The above referenced form is being submitted for your review and approval. This form is new and not intended to replace any forms previously approved by your Department. ***Please note, however, that these forms are similar to forms CH-26120-IP (04/11) OON AR and CH-26120-IP OC (04/11) OON AR that were approved by your department on June 28, 2011 under SERFF filing# MGCC-127174566, with the exception of the form number, the renewability provision, and the termination of coverage provision, which have now been revised to allow coverage for insureds age 65 and over.***

Policy Form **CH-26120-IP (01/12) OON AR** provides Vision Insurance coverage for eye examinations, lenses, frames and contact lenses when such services are obtained through one of our network providers. All benefits are subject to the Benefit Payment Rate shown in the Policy Schedule, any benefit limitations shown in the Policy Schedule, the Exclusions and Limitations, and all other provisions of the Policy.

Please note the bracketed items are intended as variable information to allow flexibility within the benefit option selections. At no time will this bracketed information be arranged in such a way to violate the laws of your state.

We intend to use either previously approved application form CH-26109-APP (04/11), that was approved by your department on June 23, 2011 under SERFF filing# MGCC-127174546, to solicit this coverage to non-Medicare eligible applicants, or application form CH-26109-APP SRM D/V (01/12), which was submitted to your department under separate cover on October 12, 2011 under SERFF filing# MGCC-127708031, when this product is marketed to Medicare eligible applicants.

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.

The required transmittal forms and certifications are enclosed herewith. Also enclosed is an Actuarial Memorandum and rates, for this submission.

Page 2

Should you need anything further in order to expedite this filing, please do not hesitate to contact me at any of the options referenced below.

Your assistance in this matter is greatly appreciated.

Sincerely,

A handwritten signature in blue ink that reads "Lavonda English".

Lavonda English
Compliance Analyst
Corporate Compliance

HealthMarkets[®]

9151 Boulevard 26 • North Richland Hills • TX 76180

P (817) 255-3155 • **F** (817) 255-8153

Lavonda.english@HealthMarkets.com • www.HealthMarkets.com

SERFF Tracking Number: MGCC-127687504 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 50011
Company Tracking Number: CH-26120-IP (01/12) OON AR
TOI: H201 Individual Health - Vision *Sub-TOI:* H201.000 Health - Vision
Product Name: 2012 CLICO SR. VISION
Project Name/Number: 2012 SR. Ancillaries/CH-26120-IP (01/12)

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/05/2011	Form	Vision Insurance Preferred Provider Organization (PPO) Policy	10/19/2011	CH-26120-IP _0112_ OON AR.pdf (Superseded)
10/05/2011	Supporting Document	Outline of Coverage	10/19/2011	CH-26120-IP OC _0112_ OON AR.pdf (Superseded)

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: [1-800-733-1110][1-800-815-8535]

VISION INSURANCE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

The attached application is a part of this Policy. Please read it and check it carefully. This Policy is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

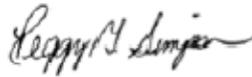
10 DAY RIGHT TO EXAMINE THE POLICY

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to Us at Our Administrative Office in North Richland Hills, Texas within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, and You will receive a full refund of all the premiums You have paid.

RENEWABILITY

This Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis.

This Policy is a legal contract between You and Us. This is a Vision Insurance Policy which provides limited benefits and is not intended to cover any medical health care expenses. **PLEASE READ YOUR POLICY CAREFULLY!**



SECRETARY



PRESIDENT

**Notice to Buyer: This Policy provides vision benefits only.
Please read it carefully.**

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POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.]

EFFECTIVE DATE OF COVERAGE: [02/15/11]

COVERED DEPENDENTS:

EFFECTIVE DATE OF COVERAGE:

[No Dependent Coverage]

[Johnette Doe]

[02/15/11]

[John Doe, Jr.]

[02/15/11]

[Johnita Doe]

[03/31/12]

POLICY NUMBER: [ABC1234567]

POLICY DATE: [02/15/11]

INITIAL PREMIUM: \$[0.00]

MODE OF PAYMENT: [Monthly]

SCHEDULE OF BENEFITS

Deductible (per Insured Person, per calendar year):

[0][10][20][30]

BENEFITS

BENEFIT PAYMENT RATE

NETWORK PROVIDER

NON-NETWORK PROVIDER*

Comprehensive Eye Examination

[100%]

[75%]

(Limited to [one] Comprehensive Eye Examination every [12] months from last date of service, per Insured Person.)

Corrective Spectacle Lenses

(standard, uncoated plastic lenses)

(In lieu of corrective contact lenses; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[0][5][10][15]

Single Vision Lenses

[100%]

[75%]

Bifocal Lenses

[100%]

[75%]

Trifocal Lenses

[100%]

[75%]

Frames

[100% up to [\$100][120]]

[100% up to [\$75][90]]

(In lieu of corrective contact lenses; limited to [one] purchase every [12] [24] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[0][5][10][15]

POLICY SCHEDULE
SCHEDULE OF BENEFITS (continued)

BENEFITS

BENEFIT PAYMENT RATE

NETWORK PROVIDER

NON-NETWORK PROVIDER*

Corrective Contact Lenses

(In lieu of Corrective Spectacle Lenses and Frames; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):
 [\$0][\$5][\$10][\$15]

Non-disposable
 Disposable
 Therapeutic

[100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]
 [100% up to [\$100][\$120]]

Contact Lens Fitting

[Not Covered]

[Not Covered]

Follow-Up Visits

[Not Covered]

[Not Covered]

***For Covered Expenses obtained through a Non-Network Provider,
 Please use the following contact information:**

EyeMed Visioncare, LLC
Administrative Office: 4000 Luxottica Place
Mason, Ohio 45040

DEFINITIONS

Benefit Payment Rate means the maximum amount of Covered Expenses which will be considered for each occurrence of a service or purchase of a supply. [Any Deductible or Copayment Amounts will be applied first and then the Benefit Payment Rate will be applied.]

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Policy unless rates are changed on all Policies issued on the same Class Basis.

Comprehensive Eye Examination means a general evaluation of the complete visual system, including the review of an Insured Person's history, conducting a general medical observation, an external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examinations, and initiation of diagnostic and treatment programs for the Insured Person. It may also include biomicroscopy, examination with cycloplegia, or mydriasis and tonometry. The comprehensive services constitute a single service entity, but need not be performed at one session. Follow-up examinations are not considered Comprehensive Eye Examinations by this definition.

Copayment means the specific dollar amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward Deductibles, if any.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Policy and has not terminated.

Covered Expenses means the charge for services and supplies listed in the POLICY SCHEDULE.

Deductible means the amount that must be paid each calendar year by any or all Insured Persons before Benefits will be paid. The Deductible amount will be applied first, and then the Copayment, if any and Benefit Payment Rate will be applied.

Effective Date of Coverage means the date coverage becomes effective under this Policy with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your natural and adopted children and step-children who are under [26] years of age (the Limiting Age).

Immediate Family means the spouse, parent, son, daughter, brother or sister of the Insured Person.

Insured Person means You or a Covered Dependent under this Policy.

Network Provider (or Preferred Provider Organization (PPO)) means an Optometrist, Ophthalmologist, Optician or Optical Supply Business that has contracted with [EyeMed Visioncare, LLC] and has agreed to provide vision care services and supplies as described by that contract to Insured Persons under this Policy. A list of the Network Providers in the network associated with this Policy is available to You at [www.eyemedvisioncare.com].

Non-Network Provider (or Non-Preferred Provider Organization (Non-PPO)) means an optometrist, ophthalmologist, optician or optical supply business that has NOT entered into a contractual agreement with [EyeMed Visioncare, LLC] or is not a participating provider at the time services are rendered to provide vision care services or supplies to Insured Persons at discounted rates.

Ophthalmologist means a physician who specializes in the medical and surgical care of the eyes and visual system as well as in the prevention of eye disease and injury. They provide a full spectrum of care including routine eye exams, diagnosis and medical treatment of eye disorders, and prescriptions for corrective optical lenses.

Optical Dispensary means an establishment licensed and authorized to prescribe and/or dispense corrective optical lenses.

Optician means one who only makes and dispenses eyeglasses and other eye corrections for optical devices.

Optometrist means a physician of optometry who provides routine vision care services and is authorized to prescribe corrective optical lenses.

Policy means this written description of coverage provided by Us to You.

We, Us and Our means The Chesapeake Life Insurance Company.

You, Your, Yours means the primary insured named in the POLICY SCHEDULE whose coverage has become effective and has not terminated.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

Additional Dependents

You may add Eligible Dependents by providing evidence of insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent and the Effective Date of Coverage for such Eligible Dependent will be shown by endorsement.

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31-day grace period, We may cancel this Policy without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period unless and until the premium due is received during the grace period.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under this Policy at any time and from time to time, provided, We have given You written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Unearned Premiums Refund

Upon the death of an Insured Person, the proceeds payable to the Insured Person or his/her estate shall include premiums paid for insurance coverage for the period beyond the end of the month in which the death occurred. Unearned Premiums shall be paid in a lump sum payment no later than thirty (30) days after the proof of the Insured Person's death has been furnished to Us.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no benefits will be payable under this Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Policy on:

1. The date Your coverage terminates, except as provided in the SPECIAL CONTINUATION FOR DEPENDENTS provision in the Policy;
2. The date such dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Upon your death or divorce, Your Covered Dependent spouse, and Your Covered Dependent child(ren) who is/are under the Limiting Age, may continue their same coverage under this Policy without evidence of insurability.

To continue coverage, Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate, and pay any required premium.

Reinstatement

If coverage under this Policy terminates due to non-payment of premium (subject to the Grace Period), We require an application for reinstatement. The reinstatement will not become effective unless We approved such application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Policy or by issuing You a new Policy.

BENEFITS

Benefits are payable under this Policy for the following Covered Expenses. Unless otherwise stated herein, all Covered Expenses are subject to:

1. [The [Deductible] [and] [Copayment] shown in the POLICY SCHEDULE (if any);]
2. The Schedule of Benefits shown on the POLICY SCHEDULE;
3. The EXCLUSIONS AND LIMITATIONS; and
4. All other provisions of this Policy.

COVERED EXPENSES

Covered Expenses are fees associated with the services and supplies covered under this Policy which are incurred by an Insured Person and not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Covered Expenses must be incurred while this coverage is in force.

Comprehensive Eye Examinations

Covered Expenses include [one] Comprehensive Eye Examination every [12] months from last date of service for each Insured Person. Covered Expenses include:

1. Consultation with Insured Person to determine their chief complaint, personal ocular disease history, occupation, lifestyle, use of vision, glasses or contact lenses, general medical history (including medications), environmental or medication allergies, family's general and ocular history, final assessment of Insured Person, management plan for Insured Person and any professionally-required reports.
2. General observation of Insured Person to assess their neurological orientation (time/place/person) and psychiatric mood and affect (depression/anxiety/agitation);
3. Clinical and diagnostic testing and evaluation related to:
 - a. the inspection of conjunctiva and sclera;
 - b. examination of pupils, orbits, ocular adnexa (including lids, lacrimal glands, lacrimal drainage, and orbits),
 - c. testing of visual acuity (not including determination of refractive error), color vision, and stereopsis;
 - d. gross visual field testing (confrontation);
 - e. basic ocular motility;
 - f. measurement of intraocular pressure;
 - g. examination of the vitreous with pupillary dilation (unless contraindicated);
 - h. ophthalmoscopic examination of optic disc(s) and posterior segment through undilated and/or dilated (unless contraindicated) pupils;
 - i. ophthalmoscopic examination of the macula, retinal periphery and/or retinal vessels with pupillary dilation (unless contraindicated);
 - j. slit lamp examination of irides, cornea(s), crystalline lenses and anterior chambers (may be completed with other instrumentation due to Insured Person's age and/or location of exam).
4. Refraction, including objective (retinoscopy or auto-refraction), subjective, and corrected visual acuities (distance and near);

Covered Expenses do not include contact lens fittings or follow-up visits.

Corrective Spectacle Lenses

Covered Expenses include [one] purchase of standard, uncoated plastic lenses every [12] months from last date of service for each Insured Person. Benefit includes single vision, bifocal and trifocal lenses. Benefit is in lieu of Corrective Contact Lenses.

Frames

Covered Expenses include [one] purchase of frames for corrective spectacle lenses every [12] [24] months from the last date of service for each Insured Person. Benefit is in lieu of Corrective Contact Lenses.

Corrective Contact Lenses

Covered Expenses include [one] purchase of contact lenses every [12] months from last date of service for each Insured Person. Benefit is in lieu of Corrective Spectacle Lenses and Frames, and includes non-disposable, disposable and therapeutic contact lenses. Benefit does not include contact lens fittings.

NETWORK AND NON-NETWORK PROVIDER SERVICES

Network Provider services and supplies are available to all Insured Persons through any participating Network Provider. The Network Provider's toll-free telephone number and website as shown on the identification card provides Insured Persons with a means to locate a Network Provider within the Insured Persons geographic area.

1. Services or supplies obtained through a Network Provider will be subject to the Network Provider Benefit Payment Rate shown in the POLICY SCHEDULE.
2. Services or supplies obtained through a Non-Network Provider will be subject to the Non-Network Provider Benefit Payment Rate shown in the POLICY SCHEDULE.

EXCLUSIONS AND LIMITATIONS

Benefits will not be provided under this Policy for expenses associated with the following:

1. Orthoptic or vision training and any associated supplemental testing;
2. Plano lenses;
3. Lens coating;
4. Two pair of glasses, in lieu of bifocals or trifocals;
5. Medical or surgical treatment of the eyes;
6. [Any type of corrective vision surgery, including LASIK surgery];
7. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
8. Any services or supplies when paid under any Worker's Compensation or similar law;
9. No-line bifocal or progressive lenses;
10. Photochromic, transition, or polycarbonate lenses;
11. Lenticular lenses;
12. Sub-normal vision aids or non-prescription lenses;
13. Services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
14. Eyeglasses when the change in prescription is less than .5 Diopter;
15. Experimental or investigational or non-conventional treatment or device;
16. Eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting, edge polishing
17. Oversized lenses;
18. High index lenses of any material type;
19. Fitting for contact lenses;
20. Follow-up visits; or
21. Charges incurred after this Policy has terminated or coverage has ended.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. The Policy;
2. Any applications for the proposed insured individuals; and
3. Any endorsements, amendments or riders attached.

All statements made by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment approved and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to [Our administrator, EyeMed Visioncare, LLC 4000 Luxottica Place Mason, Ohio 45040,] within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all Benefits due under the Policy promptly upon receipt of due Proof of Loss.

All Benefits are payable to You, however, at Our option, We may pay the provider of service instead, unless You have requested otherwise in writing prior to providing proof of loss. If any such Benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any Benefit, We may, at Our option, pay such Benefit to Your estate or any one or more of the following relatives: Your spouse; mother, father, child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Legal Action

No action at law or in equity will be brought to recover on this Policy prior to the expiration of 60 days after Proof of Loss has been filed as required under this Policy, or will any action be brought after expiration of 3 years (36 months) after the time written Proof of Loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due to Us because of past underpayment, will be made so that We receive the premiums due at the correct age.

Incontestability

After 2 years (24 months) from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the Application will be used to void the coverage, or deny a claim, unless the loss was incurred during the first 2 years following such Insured Person's Effective Date of Coverage.

Conformity

Any provision of this Policy which, on the Effective Date of Coverage, is in conflict with the statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

Change of Residence

If You move, You must notify the Company.

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: [1-800-733-1110][1-800-815-8535]

VISION INSURANCE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR FORM: CH-26120-IP (01/12) OON AR

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to health Insurance for People With Medicare available from the Company.

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. VISION INSURANCE POLICY** – The Policy is designed to provide You or Your Covered Dependents with coverage when certain losses are incurred for vision services and supplies. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the EXCLUSIONS & LIMITATIONS section.
- 3. BENEFITS** – While the Policy is in force, Covered Expenses include the fees associated with the Vision Care services and supplies shown below when provided by an authorized provider (i.e., ophthalmologist, optometrist, or optical dispensary). Payment of benefits for any such service or supply will be made in accordance with the specified Benefit Payment Rate [and any [Deductible] [and] [Copayment] Amounts] shown below. The Benefit Payment Rate is the maximum amount of Covered Expenses We will pay for each occurrence or purchase of a supply or service. [Any Deductible Amounts and/or Copayments will be applied first and then the Benefit Payment Rate will be applied.]

Deductible (per Insured Person, per calendar year): [\$0][\$10][\$20][\$30]

BENEFITS

BENEFIT PAYMENT RATE

NETWORK PROVIDER

NON-NETWORK PROVIDER

Comprehensive Eye Examination

[100%]

[75%]

(Limited to [one] Comprehensive Eye Examination every [12] months from last date of service, per Insured Person.)

Corrective Spectacle Lenses

(standard, uncoated plastic lenses)

(In lieu of corrective contact lenses; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[\$0][\$5][\$10][\$15]

Single Vision Lenses

[100%]

[75%]

Bifocal Lenses

[100%]

[75%]

Trifocal Lenses

[100%]

[75%]

BENEFITS**BENEFIT PAYMENT RATE****NETWORK PROVIDER****NON-NETWORK PROVIDER****Frames**

[100% up to [\$100][\$120]]

[100% up to [\$75][\$90]]

(In lieu of corrective contact lenses; limited to [one] purchase every [12] [24] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[\$0][\$5][\$10][\$15]

Corrective Contact Lenses

(In lieu of Corrective Spectacle Lenses and Frames; limited to [one] purchase every [12] months from last date of service, per Insured Person.)

Copayment (per Insured Person):

[\$0][\$5][\$10][\$15]

Non-disposable

[100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]

Disposable

[100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]

Therapeutic

[100% up to [\$100][\$120]]

[100% up to [\$100][\$120]]

Contact Lens Fitting

[Not Covered]

[Not Covered]

Follow-Up Visits

[Not Covered]

[Not Covered]

4. EXCLUSIONS & LIMITATIONS – Benefits will not be provided under the Policy for expenses associated with the following:

1. Orthoptic or vision training and any associated supplemental testing;
2. Plano lenses;
3. Lens coating;
4. Two pair of glasses, in lieu of bifocals or trifocals;
5. Medical or surgical treatment of the eyes;
6. [Any type of corrective vision surgery, including LASIK surgery];
7. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
8. Any services or supplies when paid under any Worker's Compensation or similar law;
9. No-line bifocal or progressive lenses;
10. Photo-chromic, transition, or polycarbonate lenses;
11. Lenticular lenses;
12. Sub-normal vision aids or non-prescription lenses;
13. Services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
14. Eyeglasses when the change in prescription is less than .5 Diopter;
15. Experimental or investigational or non-conventional treatment or device;
16. Eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting, or edge polishing;
17. Oversized lenses;
18. High index lenses of any material type;
19. Fitting for contact lenses;
20. Follow-up visits; or
21. Charges incurred after the Policy has terminated or coverage has ended.

5. RENEWABILITY – The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis.

6. BEGINNING OF COVERAGE - We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

7. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates, except as provided under the SPECIAL CONTINUATION FOR DEPENDENTS provision;
2. The date such dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a Covered Dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly Dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof, We may terminate the coverage of such person after the attainment of the Limiting Age.

8. PREMIUMS – We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis.

Premium Due (at time of application) \$ _____