

SERFF Tracking Number: MGCC-127708031 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 50014
Company Tracking Number: CH-26109-APP SRM D/V (01/12)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2012 CLICO SR. APP
Project Name/Number: 2012 SR. Ancillaries/CH-26109-APP SRM D/V (01/12)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: 2012 CLICO SR. APP

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

Implementation Date Requested: On Approval

State Filing Description:

SERFF Tr Num: MGCC-127708031 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50014

Co Tr Num: CH-26109-APP SRM State Status: Approved-Closed
D/V (01/12)

Authors: Lavonda English, Kim
Perkins

Date Submitted: 10/12/2011

Reviewer(s): Rosalind Minor

Disposition Date: 10/17/2011

Disposition Status: Approved-
Closed

Implementation Date:

General Information

Project Name: 2012 SR. Ancillaries

Project Number: CH-26109-APP SRM D/V (01/12)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Lavonda English

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Please see attached cover letter.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type: Individual

Filing Status Changed: 10/17/2011

State Status Changed: 10/17/2011

Created By: Lavonda English

Corresponding Filing Tracking Number: MGCC-
127687504; MGCC-127687519

Company and Contact

Filing Contact Information

SERFF Tracking Number: MGCC-127708031 *State:* Arkansas
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LaVonda English, Senior Compliance Analyst LaVonda.English@healthmarkets.com
 9151 Boulevard 26 817-255-3155 [Phone]
 North Richland Hills, TX 76180 817-255-8153 [FAX]

Filing Company Information

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

Filing Fees

Fee Required?	Yes
Fee Amount:	\$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	52738421

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/17/2011	10/17/2011

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Disposition

Disposition Date: 10/17/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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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	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CH-26109-APP SRM D/V (01/12)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed	CH-26109- APP SRM	Application/ Enrollment	Application Form	Initial		50.400	CH-26109- APP SRM DV _0112_.pdf



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

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR -APP READ.pdf Arkansas Rule and Regulation 19 26109.pdf	Approved-Closed	10/17/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Please refer to the Forms Schedule Tab. Comments: Please refer to Form Schedulle Tab.	Approved-Closed	10/17/2011

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not Applicable Comments:	Approved-Closed	10/17/2011

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Not Applicable - Application Filing Comments:	Approved-Closed	10/17/2011

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: This is not a PPACA related filing.	Approved-Closed	10/17/2011

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Comments:

	Item Status:	Status
Satisfied - Item: Cover Letter	Approved-Closed	Date: 10/17/2011

Comments:

Attachment:

AR - CH-26109 APP SRM DV _0112_ Filing Letter.pdf

FLESCH READABILITY CERTIFICATE

Policy or Rider
Form Number

Flesch Score

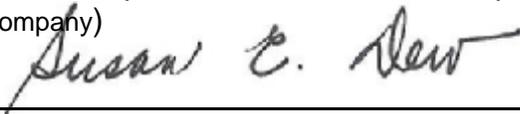
CH-26109-APP SRM D/V (01/12)

50.4

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

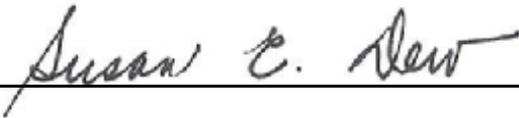
Insurer: The Chesapeake Life Insurance Company

Form Number(s):
CH-26109-APP SRM D/V (01/12)

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)



**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

Form Number

CH-26109-APP SRM DV (01/12)

DESCRIPTION

Application for Insurance

Dear Commissioner Bradford:

The above referenced application form is hereby submitted for your review and approval. This form is new and not intended to replace any forms previously approved by your Department. To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

This application form is intended to be used to solicit dental and vision coverage to Medicare eligible applicants and their dependents under the various supplemental policy forms specified on the attached "**Forms Listings**" page, which are being submitted to your department under separate cover through SERFF. The "Forms Listing" document is intended to be supporting documentation only in order to assist the Department in its review.

It is our hope that we may also be granted the flexibility to solicit coverage using this application for any future submitted/approved supplemental health insurance policies intended for use in the senior market. Of course, if/when this occurs, it will be appropriately noted in the respective form filing. This application may also be used in an electronic format.

The bracketed information is intended to be variable and to allow flexibility. Please accept our assurance that at no time will any bracketed text ever be included, omitted, or changed to reflect information that is not in compliance with applicable law.

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,

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



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

FORMS LISTING

THE CHESAPEAKE LIFE INSURANCE COMPANY

List of policy forms pending approval by Arkansas that form
CH-26109-APP SRM DV (01/12); et al will be used to solicit coverage under:

RECENTLY SUBMITTED/PENDING FORM	FORM TYPE	SUBMISSION DATE	SERFF ID
CH-26120-IP (01/12) OON AR	Vision Insurance PPO Policy	10/12/2011	MGCC-127687504
CH-26121-IP (01/12) AR	Dental Insurance PPO Policy	10/12/2011	MGCC-127687519