

SERFF Tracking Number: MGCC-127174168 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 48995
 Company Tracking Number: CH-26121-IP (04/11) AR
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
 Product Name: 2011 CLICO DENTAL
 Project Name/Number: 2011 Spring Ancillaries/CH-26121-IP (04/11)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: 2011 CLICO DENTAL

SERFF Tr Num: MGCC-127174168 State: Arkansas

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved- State Tr Num: 48995
 Closed

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: CH-26121-IP (04/11) State Status: FEES PAID
 AR

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Lavonda English, Julie
 Addy, Kim Perkins

Disposition Date: 06/16/2011

Date Submitted: 06/07/2011

Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2011 Spring Ancillaries

Status of Filing in Domicile:

Project Number: CH-26121-IP (04/11)

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: 06/16/2011

State Status Changed: 06/07/2011

Deemer Date:

Created By: Julie Addy

Submitted By: Lavonda English

Corresponding Filing Tracking Number:

Filing Description:

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.

Policy Form CH-26121-IP (04/11) AR provides Dental Insurance coverage for Covered Expenses related to various dental treatment and services as outlined in the Policy. All benefits are subject to any applicable Waiting Periods and Deductibles, and the benefit maximums and Network/Non-Network Coinsurance amounts shown in the Policy Schedule. Benefits are also subject to the Exclusions and Limitations and all other provisions of the Policy.

SERFF Tracking Number: MGCC-127174168 State: Arkansas
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TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
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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 application form CH-26109-APP (04/11), which was submitted to your department under separate cover on June 7, 2011, to solicit this product.

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.

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.

Respectfully submitted,

Lavonda English
Compliance Analyst
Lavonda.english@healthmarkets.com

Company and Contact

Filing Contact Information

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

SERFF Tracking Number: MGCC-127174168 State: Arkansas
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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	06/07/2011	48413017

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/16/2011	06/16/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Cover Letter	Lavonda English	06/07/2011	06/07/2011

SERFF Tracking Number: MGCC-127174168 State: Arkansas
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Disposition

Disposition Date: 06/16/2011

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	Outline of Coverage	Approved-Closed	Yes
Supporting Document (revised)	Cover Letter	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Dental Insurance Preferred Provider Organization (PPO) Policy	Approved-Closed	Yes
Rate	RATES	Approved-Closed	Yes

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Amendment Letter

Submitted Date: 06/07/2011

Comments:

A typo has been corrected in the cover letter.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover Letter

Comment:

LTR CH-26121-IP _0411_ [Indiv].pdf

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Form Schedule

Lead Form Number: CH-26121-IP (04/11) AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/16/2011	CH-26121-IP (04/11) AR	Policy/Cont ract/Fratern al Certificate	Dental Insurance Preferred Provider Organization (PPO) Policy	Initial		42.300	CH-26121-IP _0411_ 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]

**DENTAL 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.

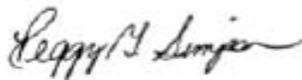
10 DAY RIGHT TO EXAMINE THE POLICY

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, refund all premiums paid and treat the Policy as if it were never issued.

RENEWABILITY

This Policy is guaranteed renewable [to age 65], 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 Policy provides limited dental benefits only and is not intended to cover all dental care expenses.



SECRETARY



PRESIDENT

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

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LIMITATIONS AND EXCLUSIONS	[X]
GENERAL PROVISIONS	[X]

{BASIC}

POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.]	EFFECTIVE DATE OF COVERAGE: [02/15/11]
COVERED DEPENDENTS: [Johnette Doe] [John Doe, Jr.] [Johnita Doe]	EFFECTIVE DATE OF COVERAGE: [02/15/11] [02/15/11] [03/31/12]
POLICY NUMBER: [ABC1234567]	POLICY DATE: [02/15/11]
INITIAL PREMIUM: \$[0.00]	MODE OF PAYMENT: [Monthly]

SCHEDULE OF BENEFITS

WAITING PERIODS:
TYPE I Covered Expenses [No Waiting Period]
TYPE II Covered Expenses [6 Month Waiting Period]

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:
TYPE I Covered Expenses [None]
TYPE II Covered Expenses [\$0][\$50][\$100]
[Deductible Family Limit: [3] Per Family each Calendar Year]

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:
TYPE I and II Covered Expenses [\$1,000][\$1,500]

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:
TYPE I and II Covered Expenses [\$5,000][\$6,000]

BENEFITS

TYPE I COVERED EXPENSES:

(Includes Preventive and Diagnostic Services as shown in the BENEFITS section)

Coinsurance	Network Provider	Non-Network Provider
	[80%][90%][100%]	[60%][70%][80%][90%][100%]

TYPE II COVERED EXPENSES:

(Includes Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the BENEFITS section)

Coinsurance	Network Provider	Non-Network Provider
	[50%][60%][70%]	[50%][60%][70%][80%][90%][100%]

{PREMIERE}

POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.]	EFFECTIVE DATE OF COVERAGE: [02/15/11]
COVERED DEPENDENTS: [Johnette Doe] [John Doe, Jr.] [Johnita Doe]	EFFECTIVE DATE OF COVERAGE: [02/15/11] [02/15/11] [03/31/12]
POLICY NUMBER: [ABC1234567]	POLICY DATE: [02/15/11]
INITIAL PREMIUM: \$[0.00]	MODE OF PAYMENT: [Monthly]

SCHEDULE OF BENEFITS

WAITING PERIODS:	
TYPE I Covered Expenses	[No Waiting Period]
TYPE II Covered Expenses	[6 Month Waiting Period]
TYPE III Covered Expenses	[12 Month Waiting Period]

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:	
TYPE I Covered Expenses	[None]
TYPE II and III Covered Expenses	[\$0][\$50][\$100]
[Deductible Family Limit:	[3] Per Family each Calendar Year]

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:	
TYPE I, II and III Covered Expenses	[\$1,000][\$1,200]

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:	
TYPE I, II and III Covered Expenses	[\$1,000][\$6,000]

BENEFITS

TYPE I COVERED EXPENSES:
(Includes Preventive and Diagnostic Services as shown in the BENEFITS section)

Coinsurance	Network Provider	Non-Network Provider
	[80%][90%][100%]	[60%][70%][80%][90%][100%]

TYPE II COVERED EXPENSES:
(Includes Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the BENEFITS section)

Coinsurance	Network Provider	Non-Network Provider
	[70%][80%][90%]	[50%][60%][70%][80%][90%][100%]

TYPE III COVERED EXPENSES:
(Includes Restorative, Endodontics, Periodontics, Prosthodontics and Oral Surgery Services as shown in the BENEFITS section)

Coinsurance	Network Provider	Non-Network Provider
	[50%][60%][70%]	[50%][60%][70%][80%][90%][100%]

DEFINITIONS

Calendar Year Benefit Maximum means the maximum amount payable under this Policy, for each Insured Person, per Calendar Year, for all Covered Expenses, after the application of any Deductible and Coinsurance. The Benefit Maximum is shown in the POLICY SCHEDULE.

Calendar Year means a twelve month period which begins at 12:01 a.m. on January 1 of any year and ends at 12:00 midnight on December 31 of that year.

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.

Coinsurance means the shared percentage of Covered Expenses after satisfying the Deductible. The Coinsurance percentage We pay is shown in the POLICY SCHEDULE.

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

Covered Expenses means the Usual and Customary Charges for Type I, [and] Type II[, and Type III] dental services shown in the BENEFITS section, which are incurred by an Insured Person while this coverage is in force and are not otherwise excluded herein. **To be a Covered Expense, the dental service must be performed by:**

1. A licensed Dentist acting within the scope of their license;
2. A licensed Physician performing dental services within the scope of their license; or
3. A licensed dental hygienist under the supervision and direction of a Dentist.

Covered Expenses must be incurred while the Insured Person's coverage under this Policy is in force.

Deductible means the amount of Covered Expenses that an Insured Person must pay before the Policy pays any benefits. Once three separate Deductibles have been met in a Calendar Year for any or all Insured Persons under Your Policy, no further Deductibles must be met for the remainder of that Calendar Year.

Dentist or Physician means a duly licensed or certified Dentist practicing within the authority of his/her license and a duly licensed or certified Physician authorized by his/her license to perform the dental services rendered. A Dentist or Physician does not include You or a member of Your immediate family.

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).

Experimental/Investigational means a drug, device or medical or dental care or treatment if:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. The informed consent document utilized with the drug, device, medical or dental care or treatment states or indicates that the drug, device, medical or dental care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
3. The drug, device, dental care or treatment or the patient informed consent document utilized with the drug, device, or medical or dental care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
4. Reliable Evidence show that the drug, device or medical or dental care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, is toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
5. Reliable Evidence show that the prevailing opinion among experts regarding the drug, device or medical or dental care or treatment is that further studies or clinical trials are necessary to determine its maximum

tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable Evidence means only published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical or dental care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical or dental care or treatment. Covered Expenses will be considered in accordance with the drug, device or medical or dental care at the time the expense is incurred.

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

Network Provider (or Preferred Provider Organization (PPO)) means a provider that holds a valid contract with the network associated with this Policy to provide dental services, treatment, and supplies to an Insured Person. A current list of the Network Providers in the network associated with this Policy is available to You at dental.chesapeakeplus.com.

Non-Network Provider (or Non-Preferred Provider Organization (Non-PPO)) means a provider who has not entered into a contractual agreement with the network associated with this Policy and/or is not active within the PPO at the time services are rendered under this Policy.

Policy means the written description of coverage provided to You.

Usual and Customary Charges ("U&C") means:

1. With respect to Non-Network Providers, the smallest of:
 - a. the actual charge;
 - b. the charge usually made for the Covered Expense by the provider who furnishes it; or
 - c. the prevailing charge made for a Covered Expense in a geographical area by those of similar professional standing; and
2. With respect to Network Providers, the negotiated rate in effect with a PPO on the date it provides a Covered Expense.

Waiting Period means the period of time following the Insured Person's Effective Date of Coverage during which no benefits will be payable for Covered Expenses. Only Covered Expenses incurred after the end of a Waiting Period will be covered under the Policy and used to satisfy the Deductible.

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

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 eligibility and insurability satisfactory to Us and upon payment of any additional premium, if required.

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

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 the 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 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.

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 further benefits will be payable under this Policy and any attached Riders, if any:

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[; or]
8. on the date You reach age 65].

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;
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 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.

Reinstatement

If coverage under this Policy terminates due to non-payment of premium, We require an application for reinstatement. The reinstatement will not become effective unless We approved such application and receive all premiums then due. 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. In any case, the reinstated coverage provides benefits only for Covered Expenses incurred after the effective date of reinstatement.

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.

IMPORTANT NETWORK INFORMATION

To minimize out-of-pocket costs, it is important that the Insured Person receives services from a Network Provider.

Network Providers and Non-Network Providers. This Policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

Using a Network Provider May Lower Costs. If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses rendered by a Non-Network Provider may cost the Insured Person more than Covered Expenses rendered by a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The Insured Person's responsibility includes the portion of the expense not payable under this Policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense.

BENEFITS

Covered Expenses

Benefits are payable under this Policy for the following Type I, [and] II[, and III] dental services and procedures when received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:

1. The Waiting Period shown in the POLICY SCHEDULE (if any);
2. The Deductible shown in the POLICY SCHEDULE (if any);
3. Any Benefit Maximums shown in the POLICY SCHEDULE;
4. The LIMITATIONS AND EXCLUSIONS; and
5. All other provisions of the Policy.

To be a Covered Expense, the dental service must be performed by:

1. A licensed Dentist acting within the scope of his/her license;

2. A licensed Physician performing dental services within the scope of his/her license; or
3. A licensed dental hygienist under the supervision and direction of a Dentist.

Covered Expenses must be incurred while the Insured Person's coverage under this Policy is in force.

A Covered Expense is considered to be incurred on the date the service is performed [unless otherwise stated below:

1. Full and partial dentures – on the date the final impression is taken;
2. Fixed bridges, crowns, inlays and onlays – on the date the teeth are first prepared;
3. Root canal therapy – on the date the pulp chamber is opened; or
4. Periodontal surgery – on the date surgery is performed].

TYPE I COVERED EXPENSES

The following Covered Expenses will be considered as Type I Covered Expenses when received by an Insured Person:

Preventive

1. Prophylaxis, limited to once every [6] months;
2. Topical application of fluoride (with or without prophylaxis), limited to once every [12] months, up to age [16][18]; and
3. Sealants (per tooth), limited to once every [36] months, up to age [16].

Diagnostic

1. Periodic oral evaluations, limited to once every [6][12] months,
2. Limited oral evaluations, limited to once every [6] months;
3. Comprehensive oral evaluations, limited to once every [6] months;
4. Detailed and extensive oral evaluations, limited to once every [6] months;
5. Re-evaluations;
6. Comprehensive periodontal evaluations, limited to once every [6] months;
7. Bitewings, limited to once every [12] months;
8. Vertical bitewings (7 to 8 films), limited to once every [36] months; and
9. Diagnostic casts.

TYPE II COVERED EXPENSES

The following Covered Expenses will be considered as Type II Covered Expenses when received by an Insured Person:

Preventive

1. Fixed or removable, unilateral or bilateral space maintainers, including recementation and removal of fixed space maintainer, up to age [6].

Diagnostic

1. Intraoral films (complete series including bitewings, periapical, or occlusal), limited to once every [36] months;
2. Extraoral films, limited to once every [36] months; and
3. Panoramic film, limited to once every [36] months.

Restorative

1. Amalgam, primary or permanent; and
2. Resin-based composite.

Adjunctive Services

1. Palliative (emergency) treatment of dental pain;
2. Fixed partial denture sectioning;
3. Local anesthesia;
4. Analgesia, up to age [13];
5. Inhalation of nitrous oxide;
6. Consultation;
7. Application – Desensitizing medicament;
8. Application – Desensitizing resin for cervical and/or root service;
9. Occlusion Analysis; and
10. Occlusion adjustment.

TYPE III COVERED EXPENSES

The following Covered Expenses will be considered as Type III Covered Expenses when received by an Insured Person:

Restorative

1. Inlay metallic;
2. Onlay metallic;
3. Inlay porcelain/ceramic;
4. Onlay porcelain/ceramic;
5. Inlay resin-based composite;
6. Inlay composite/resin;
7. Onlay resin-based composite;
8. Onlay composite/resin;
9. Crown – resin based composite;
10. Crown – resin;
11. Crown – porcelain;
12. $\frac{3}{4}$ cast crowns; noble metal, predominately base metal, cast noble metal, or porcelain/ceramic;
13. Full cast crowns; high noble metal, predominately base metal, or noble metal;
14. Recementing of inlays, onlays, or partial coverage restoration and crowns, except within the 6 months of the initial period, limited to once every [12] months;
15. Recement cast or prefabricated post and core;
16. Prefabricated crowns; stainless steel, resin, or stainless steel with resin window (primary or permanent tooth);
17. Protective restoration;
18. Sedative fillings;
19. Core buildups, including pins;
20. Pin retention in addition to restoration (per tooth), limited to [2] procedures every [12] months;
21. Cast post or core in addition to crown;
22. Each additional cast post – same tooth;
23. Each additional indirectly fabricated post;
24. Prefabricated post and core in addition to crown;
25. Each additional prefabricated post;

Endodontics

1. Pulp caps, direct or indirect (excluding final restoration);
2. Therapeutic pulpotomy (excluding final restoration);
3. Pulpal debridement, primary and permanent teeth;
4. Pulpal therapy (resorbable filling), anterior or posterior primary tooth (excluding final restoration);
5. Endodontic therapy; anterior, bicuspid, or molar (excluding final restoration)
6. Root canal; anterior, bicuspid, or molar (excluding final restoration);
7. Non-surgical treatment of root canal obstruction;
8. Incomplete endodontic therapy, inoperable or fractured tooth;
9. Internal tooth repair of perforation defects;
10. Retreatment of previous root canal therapy; anterior, bicuspid, or molar;
11. Apexification/recalcification; initial visit, interim medication replacement, and final visit (includes completed root);
12. Apicoectomy/periradicular surgery; anterior, bicuspid (first root), molar (first root), and additional roots;
13. Retrograde fillings;
14. Root amputations; and
15. Hemisection, including any root removal (excluding root canal).

Periodontics

1. Gingivectomy / gingivoplasty; one, two, or three quadrant teeth, or four/more contiguous teeth/bounded teeth spaces (per quadrant), limited to once every [36] months;

2. Anatomical crown exposure; one, two, or three quadrant teeth, or four/more contiguous teeth (per quadrant);
3. Gingival flap procedure (including root planning); one, two, or three teeth, or four/more contiguous teeth/bounded teeth spaces (per quadrant), limited to once every [36] months;
4. Apically positioned flap;
5. Hard tissue clinical crown lengthening;
6. Osseous surgery (including flap entry and closure); one, two, or three teeth, or four/more contiguous teeth/bounded teeth spaces (per quadrant), limited to once every [36] months;
7. Bone replacement grafts (first site and each additional site in quadrant);
8. Guided tissue regenerations, resorbable or non-resorbable barriers;
9. Surgical revision procedures;
10. Pedicle soft tissue graft procedures;
11. Free soft tissue graft procedures, including donor site surgery;
12. Provisional splinting, intracoronal or extracoronal;
13. Periodontal scaling and root planning; one, two, or three quadrant teeth, or four/more contiguous teeth, limited to 4 separate quadrants ever [2] years;
14. Full-mouth debridement to enable comprehensive evaluation and diagnosis, limited to once every [36] months;
15. Periodontal maintenance; and
16. Unscheduled dressing changes (performed by non-primary Dentist or dental hygienist).

Prosthodontics

1. Complete dentures, maxillary or mandibular, limited to once every [5] years;
2. Immediate dentures, maxillary or mandibular;
3. Resin-base partial dentures, maxillary or mandibular, including any conventional clasps, rests, and teeth;
4. Cast metal framework partial dentures, maxillary or mandibular, including any conventional clasps, rests and teeth;
5. One piece cast metal removable unilateral partial dentures, including any conventional clasps and teeth;
6. Adjustment of complete or partial dentures, maxillary or mandibular;
7. Repair of broken complete denture base;
8. Complete dentures for the replacement of missing or broken teeth, limited to once every [5] years;
9. Interim complete or partial dentures, maxillary or mandibular;
10. Tissue conditioning, maxillary or mandibular; and
11. Repair of resin denture base, cast framework, or replacement of broken clasp;
12. Replacement of broken teeth;
13. Addition of tooth or clasp to existing partial denture;
14. Rebase of complete or partial, maxillary or mandibular denture;
15. Reline of complete or partial, maxillary or mandibular denture; chair-side or laboratory;
16. Pontic; cast high noble metal, cast predominantly base metal, cast noble metal, porcelain fused to high noble metal; porcelain fused to predominantly base metal, porcelain fused to noble metal, porcelain/ceramic, resin with high noble metal, resin with predominantly base metal, resin with noble metal;
17. Retainer;
18. Crown (excluding provisional retainer crown, interim retainer crown, connector bar, titanium, stress breaker and precision attachment);
19. Recement fixed partial denture;
20. Cast post and core;
21. Prefabricated post and core;
22. Core build-up for retainer;
23. Coping – metal;
24. Each additional cast post (same tooth);
25. Each additional indirectly fabricated post (same tooth); and
26. Each additional prefabricated post (same tooth).

Oral Surgery

1. Extraction of erupted tooth or exposed root (elevation and/or forceps);

2. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
3. Removal of impacted tooth; soft tissue, partially boney, completely boney, or completely boney with unusual surgical procedure;
4. Surgical access of an unerupted tooth;
5. Surgical removal of residual tooth roots (actual cutting procedure);
6. Tooth transplantation / stabilization of accidentally evulsed or displaced tooth, including reimplantation from one site to another and splinting / stabilization;
7. Biopsy of oral tissue, soft or hard ("hard" is the bone or tooth);
8. Alveoloplasty, in or not in conjunction with extractions, per quadrant (excluding one to three teeth or tooth spaces per quadrant);
9. Removal of benign, odontogenic or non-odontogenic cyst / tumor, 1.25 cm in diameter and greater;
10. Incision and drainage of abscess, intraoral soft tissue (excludes intraoral soft tissue – complicated and extraoral soft tissue);
11. Suture, of recent small wounds up to 5 cm or complicated 5 cm and greater;
12. Sinus augmentation with bone or bone substitutes;
13. Frenulectomy (frenectomy or frenotomy); and
14. Excision of hyperplastic tissue (per arch) or pericoronal gingival.

{BASIC}
LIMITATIONS AND EXCLUSIONS

We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Treatment, care, services or supplies for which benefits are not specifically provided for in this Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures;
8. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
9. Oral/facial images, including intra- and extra-oral images;
10. Pulp vitality tests;
11. Chairside, labial veneers (laminates);
12. Regional block anesthesia;
13. Hospital, house, or extended care facility calls;
14. Office visits for the purpose of observation, during or after regularly scheduled hours;
15. Office visits outside of regularly scheduled hours;
16. Enamel microabrasions;
17. Services not completed by the end of the month in which coverage terminates;
18. Procedures that are begun, but not completed;
19. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
20. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
21. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
22. Orthodontic procedures;
23. Covered Expenses for which an Insured Person is not legally obligated to pay; or
24. Experimental/Investigational treatment.

{PREMIERE}

LIMITATIONS AND EXCLUSIONS

We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Treatment, care, services or supplies for which benefits are not specifically provided for in this Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures, UNLESS due to an injury or for congenital / developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;
8. The replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
9. Implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouth-guards; precision or semi-precision attachments; denture duplication; or splinting;
10. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
11. Replacement of any prosthetic appliance, crown, inlay, or onlay restoration, or fixed bridge within 5 years of the date of the last replacement, UNLESS due to an injury;
12. Oral/facial images, including intra- and extra-oral images;
13. Pulp vitality tests;
14. Post removals UNLESS in conjunction with endodontic therapy;
15. Chairside, labial veneers (laminates);
16. Intentional re-implantation, including necessary splinting;
17. Surgical procedure for isolation of tooth with rubber dam;
18. Canal preparation and fitting of performed dowel or post;
19. Regional block anesthesia;
20. Hospital, house, or extended care facility calls;
21. Office visits for the purpose of observation, during or after regularly scheduled hours;
22. Office visits outside of regularly scheduled hours;
23. Enamel microabrasions;
24. An initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one or more natural teeth lost before coverage was effective under this Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Policy;
25. Services not completed by the end of the month in which coverage terminates;
26. Procedures that are begun, but not completed;
27. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
28. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
29. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
30. Orthodontic procedures;
31. Covered Expenses for which an Insured Person is not legally obligated to pay; or
32. Experimental/Investigational treatment.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other Type III Prosthetic or Prosthodontic services are subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (1) needed to replace one or more natural teeth that were removed while this Policy was in force for the Insured Person; and (2) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

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 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 [Us][Our administrator, Core Five Solutions/Claim at P.O. Box 60 in Frisco, Texas, 75034] 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 the provider of service, 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 the Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Policy; nor may any action be brought after the expiration of 3 years 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 underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

After 2 years 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 applicable 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.

Subrogation

You agree that We shall be subrogated to Your right to damages, to the extent of the benefits provided by the Policy, for Covered Expenses that a third party is liable for or causes. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs.

You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a claim against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

SERFF Tracking Number: MGCC-127174168
 Filing Company: The Chesapeake Life Insurance Company
 Company Tracking Number: CH-26121-IP (04/11) AR
 TOI: H101 Individual Health - Dental
 Product Name: 2011 CLICO DENTAL
 Project Name/Number: 2011 Spring Ancillaries/CH-26121-IP (04/11)

State: Arkansas
 State Tracking Number: 48995
 Sub-TOI: H101.000 Health - Dental

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-127174168 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 48995
 Company Tracking Number: CH-26121-IP (04/11) AR
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: 2011 CLICO DENTAL
 Project Name/Number: 2011 Spring Ancillaries/CH-26121-IP (04/11)

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 06/16/2011	RATES	CH-26121-IP (04/11) AR	New		CH-26121-IP (0411) AR Rates 20110524.pdf

The Chesapeake Life Insurance Company

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

Dental Insurance Preferred Provider Organization (PPO) Policy

CH-26121-IP (04/11) AR

	<u>Adult</u>	<u>Child</u>
Basic	\$19.00	\$16.00
Premier	\$39.00	\$28.00

Rates are monthly

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-127174168 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 48995
 Company Tracking Number: CH-26121-IP (04/11) AR
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: 2011 CLICO DENTAL
 Project Name/Number: 2011 Spring Ancillaries/CH-26121-IP (04/11)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR -26121 READ.pdf Arkansas Rule and Regulation 19 26121.pdf ARGA 0104.pdf	Approved-Closed	06/16/2011
Satisfied - Item: Application Comments: Attachment: CH-26109-APP _0411_.pdf	Approved-Closed	06/16/2011
Satisfied - Item: Health - Actuarial Justification Comments: Attachment: CH-26121-IP (0411) AR Act Memo 20110524.pdf	Approved-Closed	06/16/2011
Satisfied - Item: Outline of Coverage Comments: Attachment: CH-26121-IP OC _0411_ AR.pdf	Approved-Closed	06/16/2011
	Item Status:	Status Date:

SERFF Tracking Number: MGCC-127174168 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 48995
Company Tracking Number: CH-26121-IP (04/11) AR
TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
Product Name: 2011 CLICO DENTAL
Project Name/Number: 2011 Spring Ancillaries/CH-26121-IP (04/11)
Satisfied - Item: Cover Letter Approved-Closed 06/16/2011
Comments:
Attachment:
LTR CH-26121-IP _0411_ [Indiv].pdf

FLESCH READABILITY CERTIFICATE

Policy or Rider
Form Number

Flesch Score

CH-26121-IP (04/11) AR

42.3

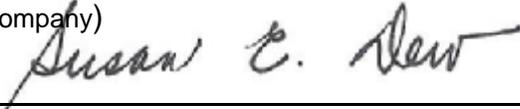
CH-26121-IP (04/11) OC AR

42.3

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)

June 7, 2011

(Date)

Arkansas Rule and Regulation 19

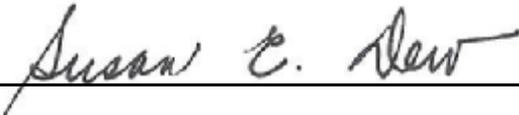
Insurer: The Chesapeake Life Insurance Company

Form Number(s):
CH-26121-IP (01/11) AR
CH-26109-APP (04/11)

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)

June 7, 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

[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]

DENTAL INSURANCE

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR POLICY FORM CH-26121-IP (04/11) AR

- 1. **READ YOUR POLICY CAREFULLY:** This Outline of Coverage provides a very brief description 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. **DENTAL INSURANCE POLICY** – The Policy is intended to provide benefits for Type I, [and] II[, and III] dental services and procedures when received by an Insured Person. Unless otherwise stated within the Policy, all benefits are subject to the Waiting Period, if any, Deductible, if any, Benefit Maximum, Limitations & Exclusions, and all other provisions of the Policy.
- 3. **SCHEDULE OF BENEFITS** – Benefits are payable under the Policy as follows:

{BASIC}

WAITING PERIODS:

TYPE I Covered Expenses
TYPE II Covered Expenses

[No Waiting Period]
[6 Month Waiting Period]

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

TYPE I Covered Expenses
TYPE II Covered Expenses
[Deductible Family Limit:

[None]
[\$0][\$50][\$100]
[3] Per Family each Calendar Year]

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I and II Covered Expenses

[\$1,000][\$1,500]

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I and II Covered Expenses

[\$5,000][\$6,000]

BENEFITS

TYPE I COVERED EXPENSES:

(Includes the Preventive and Diagnostic Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance

Network Provider
[80%][90%][100%]

Non-Network Provider
[60%][70%][80%][90%][100%]

TYPE II COVERED EXPENSES:

(Includes the Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the Policy. Certain services/procedures are subject to limitations)

Coinsurance

Network Provider
[50%][60%][70%]

Non-Network Provider
[50%][60%][70%][80%][90%][100%]

{PREMIERE}

WAITING PERIODS:

TYPE I Covered Expenses	[No Waiting Period]
TYPE II Covered Expenses	[6 Month Waiting Period]
TYPE III Covered Expenses	[12 Month Waiting Period]

DEDUCTIBLE, PER INSURED PERSON, PER CALENDAR YEAR:

TYPE I Covered Expenses	[None]
TYPE II and III Covered Expenses	[\$0] [\$50] [\$100]
[Deductible Family Limit:	[3] Per Family each Calendar Year]

CALENDAR YEAR BENEFIT MAXIMUM, PER INSURED PERSON:

TYPE I, II and III Covered Expenses	[\$1,000] [\$1,200]
-------------------------------------	---------------------

CALENDAR YEAR BENEFIT MAXIMUM, PER FAMILY:

TYPE I, II and III Covered Expenses	[\$1,000] [\$6,000]
-------------------------------------	---------------------

COVERED EXPENSES

TYPE I COVERED EXPENSES:

(Includes the Preventive and Diagnostic Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance	Network Provider	Non-Network Provider
	[80%][90%][100%]	[60%][70%][80%][90%][100%]

TYPE II COVERED EXPENSES:

(Includes the Preventive, Diagnostic, Restorative, and Adjunctive Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance	Network Provider	Non-Network Provider
	[70%][80%][90%]	[50%][60%][70%][80%][90%][100%]

TYPE III COVERED EXPENSES:

(Includes the Restorative, Endodontics, Periodontics, Prosthodontics and Oral Surgery Services as shown in the Policy. Certain services/procedures are subject to limitations.)

Coinsurance	Network Provider	Non-Network Provider
	[50%][60%][70%]	[50%][60%][70%][80%][90%][100%]

4. **BENEFITS** – Benefits are payable under the Policy for Type I, [and] II[, and III] dental procedures when received by an Insured Person. Unless otherwise stated herein, all benefits are subject to:
1. The Waiting Period shown in the POLICY SCHEDULE (if any);
 2. The Deductible shown in the POLICY SCHEDULE (if any);
 3. Any Benefit Maximums shown in the POLICY SCHEDULE;
 4. The LIMITATIONS AND EXCLUSIONS; and
 5. All other provisions of the Policy.

To be a Covered Expense, the dental service must be performed by:

1. A licensed Dentist acting within the scope of his/her license;
2. A licensed Physician performing dental services within the scope of his/her license; or
3. A licensed dental hygienist under the supervision and direction of a Dentist

Covered Expenses must be incurred while the Insured Person's coverage under the Policy is in force.

A Covered Expense is considered to be incurred on the date the service is performed [unless otherwise stated below:

1. Full and partial dentures – on the date the final impression is taken;
2. Fixed bridges, crowns, inlays and onlays – on the date the teeth are first prepared;
3. Root canal therapy – on the date the pulp chamber is opened; or

4. Periodontal surgery – on the date surgery is performed].

5. PREFERRED PROVIDER ORGANIZATION (PPO) - To minimize out-of-pocket costs, it is important that the Insured Person receives services from a Network Provider.

Network Providers and Non-Network Providers. The Policy provides benefits for Covered Expenses obtained from both Network Providers and Non-Network Providers.

Using a Network Provider May Lower Costs. If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Expenses received from a Network Provider. Covered Expenses rendered by a Non-Network Provider may cost the Insured Person more than Covered Expenses rendered by a Network Provider. Covered Expenses for a Non-Network Provider's services may be substantially lower than the actual charges. The Insured Person's responsibility includes the portion of the expense not payable under the Policy, plus all of the Non-Network Provider's charges that exceed the Covered Expense.

6. {BASIC} EXCLUSIONS & LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Treatment, care, services or supplies for which benefits are not specifically provided for in this Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures;
8. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
9. Oral/facial images, including intra- and extra-oral images;
10. Pulp vitality tests;
11. Chairside, labial veneers (laminates);
12. Regional block anesthesia;
13. Hospital, house, or extended care facility calls;
14. Office visits for the purpose of observation, during or after regularly scheduled hours;
15. Office visits outside of regularly scheduled hours;
16. Enamel microabrasions;
17. Services not completed by the end of the month in which coverage terminates;
18. Procedures that are begun, but not completed;
19. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
20. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
21. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
22. Orthodontic procedures;
23. Covered Expenses for which an Insured Person is not legally obligated to pay; or
24. Experimental/Investigational treatment.

6. {PREMIERE} EXCLUSIONS & LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Treatment, care, services or supplies for which benefits are not specifically provided for in the Policy;
2. Charges exceeding the Maximum Benefit Amount, if any;
3. Attempted suicide or any intentionally self-inflicted injury;
4. Directly or indirectly engaging in illegal activity;
5. Treatment of disturbances of the temporomandibular joint (TMJ);
6. A service not furnished by a Dentist, UNLESS by a dental hygienist under the Dentist's supervision and x-rays are ordered by the Dentist;
7. Cosmetic procedures, UNLESS due to an injury or for congenital / developmental malformation. Facing on crowns, or pontics, posterior to the second bicuspid is considered cosmetic;

8. The replacement of full and partial dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function;
9. Implants; replacement of lost or stolen appliances; replacement of orthodontic retainers; athletic mouth-guards; precision or semi-precision attachments; denture duplication; or splinting;
10. Plaque control; completion of claim forms; broken appointments; prescription or take-home fluoride; or diagnostic photographs;
11. Replacement of any prosthetic appliance, crown, inlay, or onlay restoration, or fixed bridge within 5 years of the date of the last replacement, UNLESS due to an injury;
12. Oral/facial images, including intra- and extra-oral images;
13. Pulp vitality tests;
14. Post removals UNLESS in conjunction with endodontic therapy;
15. Chairside, labial veneers (laminates);
16. Intentional re-implantation, including necessary splinting;
17. Surgical procedure for isolation of tooth with rubber dam;
18. Canal preparation and fitting of performed dowel or post;
19. Regional block anesthesia;
20. Hospital, house, or extended care facility calls;
21. Office visits for the purpose of observation, during or after regularly scheduled hours;
22. Office visits outside of regularly scheduled hours;
23. Enamel microabrasions;
24. An initial placement of a partial or full removable denture or fixed bridgework if it involves the replacement of one or more natural teeth lost before coverage was effective under the Policy. This limitation does not apply if replacement includes a natural tooth extracted while covered under the Policy;
25. Services not completed by the end of the month in which coverage terminates;
26. Procedures that are begun, but not completed;
27. Those services for which there would be no charge in the absence of insurance or for any service or treatment provided without charge;
28. Services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries;
29. Care or treatment of a condition for which benefits are payable under any Workers' Compensation Act or similar law;
30. Orthodontic procedures;
31. Covered Expenses for which an Insured Person is not legally obligated to pay; or
32. Experimental/Investigational treatment.

Tooth Missing But Not Replaced Rule

Coverage for the first installation of removable dentures; fixed bridgework and other Type III Prosthetic or Prosthodontic services are subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (1) needed to replace one or more natural teeth that were removed while the Policy was in force for the Insured Person; and (2) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

7. **RENEWABILITY** – The Policy is guaranteed renewable [to age 65], 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.
8. **BEGINNING OF COVERAGE** - 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.
9. **TERMINATION OF COVERAGE** –

You

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

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[; or]
8. on the date You reach age 65].

Covered Dependents

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

1. the date Your coverage terminates, except as provided in 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 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.

10. 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

June 7, 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-26121-IP (04/11) AR

CH-26121-IP OC (04/11) AR

DESCRIPTION

Dental Insurance Preferred Provider
Organization (PPO) Policy
Outline of Coverage

Dear Commissioner Bradford:

The above referenced forms are hereby submitted for your review and approval. These forms are new and not intended to replace any forms previously approved by your Department.

Policy Form **CH-26121-IP (04/11) AR** provides Dental Insurance coverage for Covered Expenses related to various dental treatment and services as outlined in the Policy. All benefits are subject to any applicable Waiting Periods and Deductibles, and the benefit maximums and Network/Non-Network Coinsurance amounts shown in the Policy Schedule. Benefits are also subject to 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 application form CH-26109-APP (04/11), which was submitted to your department under separate cover on June 7, 2011, to solicit this product.

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.

If you have any questions or if anything further is needed to expedite the review of this filing, please call me collect at (817) 255-3155.

Your assistance in this matter is greatly appreciated.

Respectfully submitted,

Lavonda English
Compliance Analyst
Lavonda.english@healthmarkets.com

SERFF Tracking Number: MGCC-127174168 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 48995
 Company Tracking Number: CH-26121-IP (04/11) AR
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: 2011 CLICO DENTAL
 Project Name/Number: 2011 Spring Ancillaries/CH-26121-IP (04/11)

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)
06/06/2011		Supporting Cover Letter Document	06/07/2011	LTR CH-26121-IP _0411_ [Indiv].pdf (Superseded)