

SERFF Tracking Number: MGCC-127174467 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 49006
Company Tracking Number: CH AE 26023 (04/11)
TOI: H201 Individual Health - Vision Sub-TOI: H201.000 Health - Vision
Product Name: VISION (26023 5/07)
Project Name/Number: 2011 Spring Ancillaries/CH AE 26023 (04/11)

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: VISION (26023 5/07)

SERFF Tr Num: MGCC-127174467 State: Arkansas

TOI: H201 Individual Health - Vision

SERFF Status: Closed-Approved-
Closed State Tr Num: 49006

Sub-TOI: H201.000 Health - Vision

Co Tr Num: CH AE 26023 (04/11) State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Lavonda English, Julie
Addy, Kim Perkins

Disposition Date: 06/23/2011

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 AE 26023 (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: 06/23/2011

State Status Changed: 06/23/2011

Deemer Date:

Created By: Julie Addy

Submitted By: Lavonda English

Corresponding Filing Tracking Number:

Filing Description:

Please refer the attached cover letter.

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

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	\$50.00	06/07/2011	48419886

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/23/2011	06/23/2011

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Disposition

Disposition Date: 06/23/2011

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	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Vision Insurance Policy Outline of Coverage	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CH AE 26023 (04/11)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/23/2011	CH AE 26023 (04/11)	Policy/Cont ract/Fratern al	Vision Insurance Policy Outline of Coverage	Initial		52.000	CH AE 26023 _0411_.pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					

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

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Policy to which it is attached and is subject to all the provisions of the Policy which are not inconsistent with this endorsement.

1. The **Renewability** provision on the **FACE PAGE** is hereby revised as follows:

RENEWABILITY

This Policy is guaranteed renewable to age 75, 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. The amount of premium for this Policy may change in amount by reason of an increase in the age of an Insured Person.

2. The **Eligible Dependent** definition under the **DEFINITIONS** section is hereby revised as follows:

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).

3. Number [8.] under the **You** provision of the **TERMINATION OF COVERAGE** section is hereby revised as follows:

[8.] On the date You reach the age of 75.

4. Number [2.] under the **Special Continuation Provision For Dependents** provision of the **TERMINATION OF COVERAGE** section is hereby revised as follows:

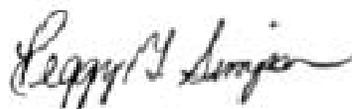
[2.] Your attainment of age 75;

Any Covered Services payable pursuant to this Amendatory Endorsement will not be duplicated under any optional benefit rider that may be attached to the Insured Person's Policy.

The provisions of this Amendatory Endorsement are effective on the Policy Date, the Insured Person's Effective Date of Coverage, or the date stated herein, whichever is later.

In Witness whereof, the Insurance Company has caused this Amendatory Endorsement to be signed by its President and Secretary.

Signed for Chesapeake Life Insurance Company at North Richland Hills, Texas.



SECRETARY



PRESIDENT

SERFF Tracking Number: MGCC-127174467
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State: Arkansas
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 Sub-TOI: H201.000 Health - Vision

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

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

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/23/2011
Comments:		
Attachments:		
AR -CH AE 26023 _0411_ READ.pdf		
Arkansas Rule and Regulation 19 26120.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	06/23/2011
Comments:		
Attachment:		
CH-26109-APP _0411_.pdf		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	06/23/2011
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	06/23/2011
Comments:		
Attachment:		
CH-26023-IP _507_ OC AR _0411_.pdf		

	Item Status:	Status Date:
Satisfied - Item: Cover letter	Approved-Closed	06/23/2011
Comments:		

SERFF Tracking Number: MGCC-127174467 *State:* Arkansas
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Attachment:

LTR CH AE 26023-IP and OC AR.pdf

FLESCH READABILITY CERTIFICATE

Policy or Rider
Form Number

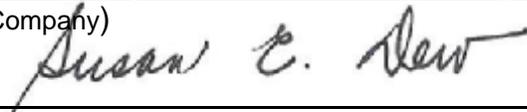
Flesch Score

CH AE 26023 (04/11)
CH-26023-IP (5/07) OC AR (04/11)

52
52

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):

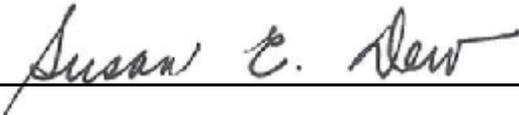
CH AE 26023 (04/11)

CH-26023-IP (5/07) OC AR (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)



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 FPEL]

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]

Applicant 1

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

Applicant 2

Lifetime Maximum Benefit Amount:

\$5,000] \$10,000] \$15,000] \$20,000] \$25,000] \$30,000] \$40,000]

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]

Applicant 1

Lifetime Maximum Benefit Amount:

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

Applicant 2

Lifetime Maximum Benefit Amount:

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

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

VISION INSURANCE POLICY OUTLINE OF COVERAGE for Form: CH-26023-IP (5/07) AR

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

Covered Expenses include the following:

BENEFITS

BENEFIT PAYMENT RATE

	<u>Network Provider</u>	<u>Non- Network Provider</u>
Comprehensive Eye Examination [(Limited to [one] Comprehensive Eye Examination every [12] months from last date of service, per Insured Person.)]	[100%]	[100%] up to [\$30]
Corrective Spectacle Lenses (standard, uncoated plastic lenses) [(Limited to [one] purchase every [12] months from last date of service, per Insured Person.)]		
Single Vision Lenses	[100%]	[75%]
Bifocal Lenses	[100%]	[75%]
Trifocal Lenses	[100%]	[75%]
Corrective Contact Lenses [(In lieu of corrective spectacle lenses; limited to [one] purchase every [12] months from last date of service, per Insured Person.)]		
Non-disposable	[100%] up to [\$40]	[100%] up to [\$30]
Disposable	[100%] up to [\$40]	[100%] up to [\$30]
Therapeutic	[100%]	[75%]
Frames	[Not Covered]	[Not Covered]
Contact Lens Fitting	[Not Covered]	[Not Covered]
Follow-Up Visits	[Not Covered]	[Not Covered]

- 4. LIMITATIONS AND EXCLUSIONS.** Certain expenses that You or Your Covered Dependents may incur for vision care do not qualify as Covered Expenses under the Policy. The Policy does not cover the following:
1. orthoptic or vision training and any associated supplemental testing;
 2. plano lenses;
 3. lens coating;
 4. two pair of glasses, in lieu of bifocals or trifocals;
 5. medical or surgical treatment of the eyes;
 6. [any type of corrective vision surgery, including LASIK surgery];
 7. any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
 8. any services or supplies when paid under any Worker's Compensation or similar law;
 9. no-line bifocal or progressive lenses;
 10. photochromic, transition, or polycarbonate lenses;
 11. lenticular lenses;
 12. sub-normal vision aids or non-prescription lenses;
 13. services rendered or supplies purchased outside the U.S. or Canada, unless the Insured Person resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
 14. eyeglasses when the change in prescription is less than .5 Diopter;
 15. experimental or investigational or non-conventional treatment or device;
 16. eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting, edge polishing
 17. oversized lenses;
 18. high index lenses of any material type;
 19. fitting for contact lenses;
 20. follow-up visits;
 21. frames for corrective spectacle lenses; or
 22. charges incurred after this Policy has terminated or coverage has ended.

LIMITATIONS

Covered Expenses for services and supplies will be limited to once every 12 months from the last date of service.

- 5. RENEWAL CONDITIONS.** The Policy is guaranteed renewable to age 75, 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. The amount of premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.
- 6. PREMIUMS.** Premiums are payable to the Company at its Administrative office. The Company reserves the right to change the table of premiums on a class basis, becoming due under the Policy at any time provided 31 days advance written notice is given.

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 AE 26023 (04/11)
CH-26023-IP (05/07) OC AR (04/11)

DESCRIPTION

Amendatory Endorsement
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.

The enclosed Amendatory Endorsement is intended to amend the following Vision Insurance Policy that was approved by your state as indicated below:

POLICY FORM NUMBER	SERFF NUMBER	DISPOSITION DATE
CH-26023-IP (5/07) AR	MGCC-125182588	06/29/2001

The enclosed outline of coverage form has also been revised accordingly. 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.

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